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ABSTRACT

The document consists of a series of in-service training sessions designed to be used by early intervention agencies in helping child care personnel mainstream young children with special needs. A glossary of disability-related terms is followed by an outline of eight in-service sessions which address the following topics: managing mainstreaming; welcoming parents as partners in child care; adapting environments for mainstreaming; using outside resources to make mainstreaming work; physical management of children in mainstreaming; communication and mainstreaming; caring for children with apnea problems using apnea monitors; and behavior management in mainstreaming. Intended outcome, length of session, objectives, activities, and print resources are listed for each session topic. Over half the document consists of the handouts cited as resources in the in-service session outlines. (JW)

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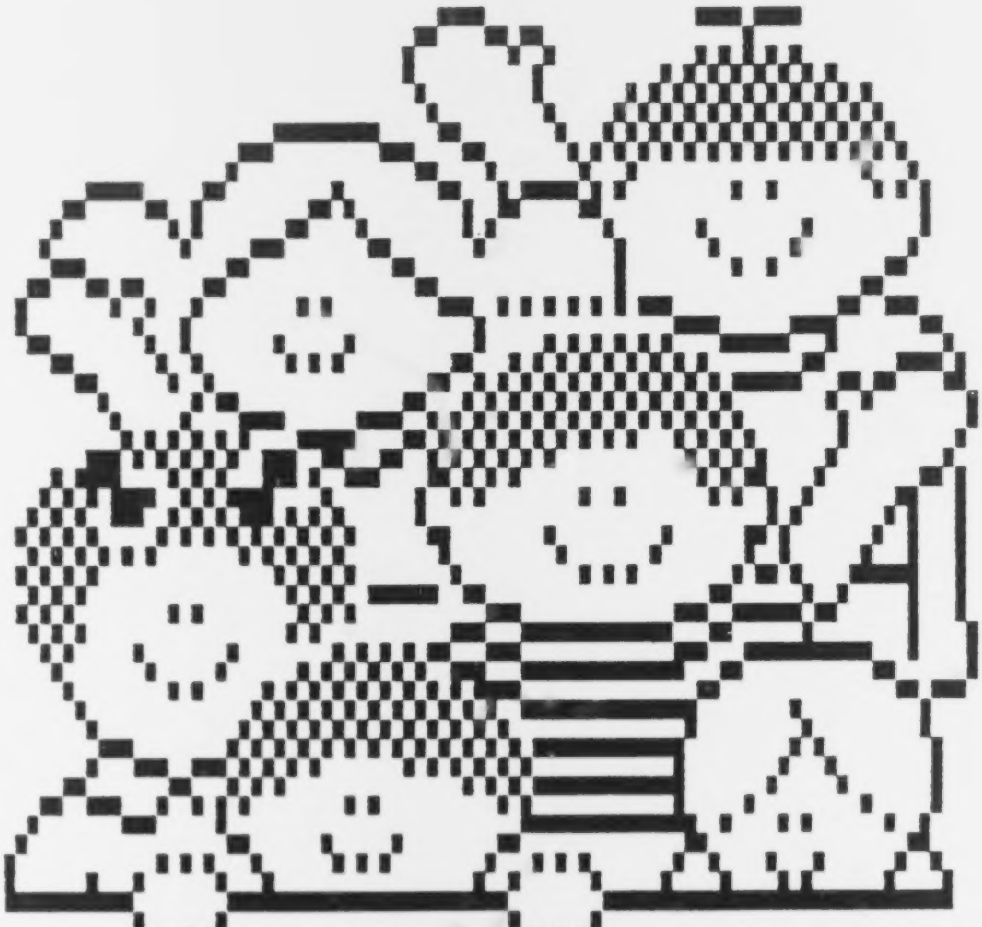
MAINSTREAMING WORKS!
VOLUME II
IN-SERVICE TRAINING GUIDES
FOR
MAINSTREAMING IN CHILD CARE CENTERS



MAINSTREAMING WORKS!

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June 1986

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MAINSTREAMING WORKS!

VOLUME II

IN-SERVICE TRAINING GUIDES

FOR

MAINSTREAMING IN CHILD CARE CENTERS

The development of this material was supported in part by a grant to IMPACT, Inc., from the Department of Health and Human Services, Administration on Developmental Disabilities; and the Florida Developmental Disabilities Planning Council.

INSERVICE TRAINING GUIDES

VOLUME II

MAINSTREAMING WORKS!

- C O N T E N T S -

INTRODUCTION

ACKNOWLEDGEMENTS AND SOURCES

GLOSSARY OF TERMS

INTENDED OUTCOMES, PERFORMANCE OBJECTIVES, ACTIVITIES, AND RESOURCES...

- MANAGING MAINSTREAMING
- WELCOMING PARENTS AS PARTNERS IN CHILD CARE
- ADAPTING ENVIRONMENTS FOR MAINSTREAMING
- USING OUTSIDE RESOURCES TO MAKE MAINSTREAMING WORK
- PHYSICAL MANAGEMENT OF CHILDREN IN MAINSTREAMING
- COMMUNICATION AND MAINSTREAMING
- CARING FOR CHILDREN WITH APNEA PROBLEMS USING APNEA MONITORS
- BEHAVIOR MANAGEMENT IN MAINSTREAMING

RESOURCES

Resource #1A not included--as received by Facility.

INTRODUCTION

This publication is the result of a grant to IMPACT, Inc., from the Florida Developmental Disabilities Planning Council. The intent of the grant was to increase the child care options available to parents of children with special needs. We sought to move towards that goal by creating a three-part training program to encourage mainstreaming in child care centers. The first part, a Special Needs Training Module, was produced in cooperation with Deborah Walters and the State Department of Health and Rehabilitative Services, Children, Youth and Families Program Office, and will be administered throughout the State of Florida primarily through that office, as well as through IMPACT, Inc.

The second part is this volume of Inservice Training Guides. These guides are designed to be used by any early intervention agency or vendor in cooperation with school board and HRS officials to coordinate ongoing resource help to child care center personnel who mainstream children with special needs. It is assumed that child care personnel requesting these inservice sessions have already attended Part I, the 8-hour Special Needs module, but it is not required that they do so.

The third part is a booklet, "Caring for Children with Special Needs in Child Care Centers: Answers for Owners and Operators."

INTRODUCTION (Continued)

This booklet is included as a management resource in the other two parts, but can also stand alone as a handout for child care center owners and operators.

The inservice guides are outlines of topics most often requested by child care center personnel involved in mainstreaming. The following steps are suggested for their use.

1. Determine a need for inservice training in your area through surveying child center personnel.

2. Teach the initial 8-hour Special Needs Training Module.
3. Send a follow-up letter to child care centers, listing the additional inservice training topics.
4. Schedule inservice training on an 'as-requested' basis.

> NOTE: The initial 8-hour Special Needs module is content-specific. Great care was taken to develop a schedule and resources that would "teach themselves." The Inservice Training Guides are much more flexible. They are designed to inform and guide early intervention agency staff and licensed OT, PT, and Speech Professionals in conducting inservice training for a special group of people: child care center personnel.

IT IS VERY IMPORTANT THAT THE INSTRUCTOR STAFFING REQUIREMENTS BE FOLLOWED FOR EACH TRAINING GUIDE.

There is no substitute for a fluent signer, an OT or PT for teaching feeding and lifting skills, or a special educator for reviewing IEPS with child care personnel.

The guides are designed to be used by an early intervention agency which acts as a clearing house, using consultants as needed, who read the guides to discover what is required of them for a given inservice session.

Agencies should feel free to add resource material as appropriate, although it is suggested that they not delete any of the material provided in an inservice guide.

Time frames for the inservice sessions vary, with most taking about two hours. The exception is Caring for Children with Apnea Problems, which takes 6-8 hours, depending on the CPR course chosen.

INTRODUCTION

Children with apnea problems are not strictly what we term "handicapped," but they have a special need which causes them to be barred from most child care settings. The need can be met if one child care center in a community will make the committment to train all of its staff in CPR and apnea monitor use procedures.

The inservice sessions need not proceed in any particular order. However, you are encouraged to provide Managing Mainstreaming first whenever possible. Mainstreaming works best when owners, operators, and staff are philosophically committed to the normalization principles covered in this inservice session.

It is hoped that these guides will aid you in facilitating mainstreaming in child care settings.

ACKNOWLEDGEMENTS AND SOURCES

This collection of materials could not have been completed without the generous contributions of the following people, agencies, or publications:

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National Information Center for
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P.O. Box 1492
Washington, DC 20013

When You Care for Handicapped Children ($15.00)
Media Services Division 151-X
Texas Department of Human Resources
P.O. Box 2960
Austin, Texas 78769

Project Headstart
Mainstreaming Preschoolers Series ($6.00 each)
Superintendent of Documents
U.S. Government Printing Office
Washington, DC 20402

Values Survey
Milton Rokeach
Halgren Tests
Seattle, Washington 98119

Preschool Planning Board
P.O. Box 2331
Olympia, Washington 98507

Training Manual for Exceptional Student Aides
Florida Diagnostic Learning Resources Center
Collier County Public Schools
3710 Estey Avenue
Naples, Florida 33942

Department of Community Affairs
Florida Board of Building Codes and Standards
Division of Technical Assistance - Bureau of Codes
2571 Executive Center Circle
Tallahassee, Florida 32301

Ask for Accessibility Standards, CH. 553, Part V.

GLOSSARY OF TERMS

Adaptive Behavior - Actions that are appropriate to the situation which shows the child's ability to change a specific behavior to adapt to the demands of a particular situation.

Ambulation - The ability to move from place to place independently.

ARC - Association for Retarded Citizens

Autism - Neurological condition in which a child has severe problems in communication and behavior. Children with autism are unable to relate to adults or other children in a normal manner. There is no cure for autism, however there are different treatment programs that can help the child who has autism. Through participation in an early intervention program, this child can learn to speak, take care of personal needs and act approriately in social situations.

Cause of Autism: Cause of Autism is not known

Characteristics of Autism include:

- o withdrawal from contact with others
- o very poor social relationships
- o may exhibit behavioral problems which may include repetitive or aggressive behaviors
- o abnormal responses to sensations
- o serious impairment in general intellectual functioning
- o speech and language difficulties

Braille - A system of writing for individuals who are blind that uses characters made up of raised dots.

Cerebral Palsy - Injury to the brain which affects the control of movements. How severely the child is affected depends on how much damage has occurred in the brain and which muscles in the body have been affected by the brain damage. There is no cure for cerebral palsy, however with early intervention from physicians, physical therapists, speech

therapists and other professionals, a child's ability to function to his or her maximum potential will greatly increase.

Cause of Cerebral Palsy: The cause of Cerebral Palsy is not always known, however the following factors may contribute to a child having Cerebral Palsy:

- o infections during pregnancy
- o RH factor incompatability
- o complications during delivery
- o injury or infection

Types of Cerebral Palsy include:

- o **Athetoid** - Characterized by involuntary, uncontrolled motion
- o **Ataxic** - Characterized by a disturbed sense of balance and depth perception
- o **Spastic** - Characterized by tense, stiff contracted muscles

Cognitive Functioning - Ways in which children learn about and understand concepts and ideas. Children must understand and know about concepts before they can talk about them.

Communication Disorder - Speech or language impairment involving problems with speaking or understanding.

Types of Speech Impairments include:

- o **Articulation Disorder** - The child's production of speech is very different from that of other children who speak the same language. Articulation problems may range from mild, moderate to severe.
- o **Stuttering**- Speech impairment in which the normal flow and rhythm of speech is interrupted. Stuttering may range from mild, moderate to severe.

- Voice Disorders - Involves the loudness, pitch or quality of the voice. The voice may be horse, raspy, strained or nasal. The child's voice may be too loud or may be as quiet as a whisper.

Types of Language Impairments include:

- Receptive - The child has difficulty in understanding the spoken language. The child may not understand anything said or may understand single words, but not whole sentences or directions. These problems may be mild and not easily noticable or so severe that the child appears to understand almost nothing.

- Expressive- Impairment that interfers with speaking. This child will probably have a limited vocabulary or in more severe cases the child may not speak at all.

Cystic Fibrosis - Inherited condition in which the mucous glands, including those in the lungs secrete very sticky mucous resulting in digestion and breathing problems. Children having this problem have difficutly in the digestion of food, because it affects the production that helps break food down. Children having Cystic Fibrosis experience frequent espisodes of pneumonia because of the build-up of mucous in the lungs.

Developmental Disability - Mental, physical or emotional condition which effects the normal development of a child and is manifested during the development period (before age 22).

Down Syndrome - Genetic disorder which occurs before birth resulting from improper chromosomal division. This causes physical and mental delays. Children with Down Syndrome may have mild, moderate or severe mental retardation.

Characteristics of a child with Down Syndrome may include:

- o flattened facial features
- o folds at inner corners of eyelids
- o short neck
- o small mouth
- o small head
- o heart disorders in about 40% of these children
- o speech delays

Early Intervention - Providing programs and services for children with developmental delays from birth through five years of age. These programs are individualized for each child with treatment plans addressing the child's developmental needs. Speech, physical and occupational therapy are provided as needed which will strengthen different developmental areas which include fine and gross motor activities, self help skills, communciation skills and socialization. Through early intervention, the child will be better able to maximize his or her developmental potential.

Emotional Disturbances - An abrupt break, slowing down or postponement in developing and maintaining meaningful relationships with other persons, and/or in developing a positive and true sense of self. The child who is emotionally disturbed may or may not be considered developmentally disabled, depending on whether his or her learning, self direction, self care or capacity for independent living also is affected. Through early intervention and treatment from psychiatric therapy, counseling and in some cases medicine, positive improvement in a child's behavior is possible.

Cause of Emotional Disturbances: The exact causes of Emotional Disturbance are not completely known.

Characteristics of Emotional Disturbance include:

- o **Withdrawn Behavior** This child's spends most of his or her time away from the group. The child appears to feel uncomfortable when people or activities get too close. A child who is withdrawn is usually uncomfortable when faced with a situation he or she doesn't know how to handle especially if it is a new experience. The child who is withdrawn seems to have few interests and frequently needs self comfort in the form of thumb - sucking, rocking, or pulling on their hair or ears.

Anxious Behavior - A child is so anxious for a long period of time that he or she is unable to concentrate on anything other than their fear or a specific situation. An example would be fear that something will happen to the child's family. This anxious behavior may be centered around one object (dogs, school, trains) and may become so limiting to the child that he or she is unable to function normally. An anxious child often looks worried and cries a lot. Some children will bite their nails, or frequently blink their eyes. The anxious child may be awkward or overly cautious. This child is eager to do well and not make mistakes.

- Aggressive Behavior- This child has angry outbursts, hurts others or may destroy toys and other objects. The child who is disturbed will react to others in forceful ways (hitting, biting, scratching, kicking) or through verbal aggression (shouting, screaming and name calling). A child may act out with anger only in certain situations, (when the child can't have a toy) or during times of stress (when the child is tired or has been confined to a small area for a long time). A child who shows extreme aggressive behavior is deeply angry and very suspicious of others. Through this behavior a child is actually covering up his or her sense of fear, vunerability and inferiority.

- Hyperactive Behavior - A child who show's this type of behavior is constantly on the move and is often over excited. This child cannot wait for explanations or turns and has difficulty in relaxing to watch or listen to what is going on. The hyperactive child has extreme mood swings and behavior is very inconsistent which may result in difficulty in relationships with others.

Epilepsy - Sudden temporary excess of energy in the brain which interrupts ("short circuts") normal activity and results in a seizure. Epilespy is not contagious and more than 80% of the cases can be successfully controlled with medication.

Cause of Epilepsy: Often the cause of epilepsy is unknown, however the following factors may contribute to a child having epilepsy:

- o head wounds
- o chemical imbalance
- o brain injury before, during or after birth
- o childhood fevers
- o poor nutrition

Types of Epileptic Seizures include:

- o **Petit Mal** - Characterized by "blank spells", losing awareness, slight twitching, staring and blinking. This form of seizure is most common in children from 6-14 years of age and only lasts for a few seconds.

- o **Grand Mal** - Characterized by falling, loss of consciousness, stiffening, shaking of the entire body and irregular breathing. This type of seizure may last for several minutes and occur frequently or very rarely.

- o **Psycho Motor** - Characterized by a period of mental confusion followed by pointless or repetitive movement, pain or dizziness.

Hearing Aid - Mechanical aid used to make sounds louder. The effectiveness of the hearing aid depends on the severity of the hearing loss.

Hearing Impaired - The degree of hearing loss a child has. A child is considered to have a hearing disability if he or she is hard of hearing or deaf. The hearing loss may be mild, moderate, severe or profound.

- o **Hard of Hearing** - Hearing capability is impaired, however with the use of a hearing aid, the child will usually be able to function in every day situations.

- **Deaf** - Hearing capability is so impaired that a child is unable to use it in everyday situations with or without a hearing aid.

Types of Hearing Losses:

- **Conductive Hearing Loss** - Occurs when there is a problem in the outer or middle ear which carries sound into the inner ear. This type of loss is less severe than a sensorineural loss and can usually be reduced or eliminated through medical treatment.

Causes of Conductive Hearing Loss:

- infections that fill the ear with fluid
- ruptured ear drum
- build-up of ear wax in the ear
- damage caused by a foreign object
- allergies

- **Sensorineural Hearing Loss** - Occurs when there is a problem with the inner ear or with the nerves that carry sound to the brain. This type of hearing loss is permanent and more severe. It cannot be cured or reduced by medical treatment, however often this type of hearing loss can be helped by a hearing aid.

Causes of Sensorineural Hearing Loss:

- diesease during pregnancy
- heredity
- childhood diseases: mumps, measles, chickenpox
- viral infections
- physical damage to head or ear
- excessive intense noise

Individualized Education Plan (IEP) - A written plan that states a child's present level of functioning and an outline of the developmental goals that a child should be working toward achieving. Each child is given tasks to work on in the following areas: fine and gross motor, communication, self-help, cognitive, and socialization.

Integration - Education of children with special needs with non-handicapped children to the maximum extent appropriate.

Learning Center - One area of interest such as music, art, math, language art and woodworking in which the teacher prepares the environment in which the child can freely explore.

Learning Disabilities - Problem with understanding and using written or spoken language. This handicap is often referred to as invisible and is difficult to diagnose. Children with learning disabilities most often have average or above average intelligence. These chidren may often develop behavior problems and may become disruptive at home, in child care centers and in school. With an early diagnosis, and early intervention by special educational, medical and social services professionals most children having a learning disability will lead normal productive lives.

Cause of Learning Disabilities: There is no known cause.

Warning signs of possible Learning Disabilities:

- o child does poorly in reading, spelling, writing or artithmetic, even though teachers strongly feel that the child could do better if he or she tried harder.
- o child is poorly coordinated, clumsy and awkward. The child has difficulty in writing, tying shoes or catching balls.
- o child is confused in language, speech or following directions.
- o child is usually forgetful or doesn't pay attention.

Mainstreaming - Helping children with different types of handicaps live, learn and work in everyday situations where they are given the opportunity to become as independent as possible. This process includes placing handicapped children with non-handicapped children in child care centers, classrooms, recreational activities and other situations where they can learn and share the same experiences as other children their own age.

Mental Retardation - An overall slowness in development. The intelligence of a child who is mentally retarded is well below that of the average population which results in the child's learning capability being below average, as well as affecting the child's social relationships and future ability to work.

Degree of Mental Retardation:

- **Mild Retardation -** Children who are midly retarded will learn considerably slower than other children of the same age. These children will do better with gross motor activities, but will have some trouble speaking and coordinating use of their eyes and hands. They will be able to learn most of the activities, however will probably require more assistance and time to complete an activity or task.

- **Moderate Retardation -** Children who are moderately retarded will be further behind in all areas of development. These children will often be very clumsy and very delayed in their speech development. A child who is moderately retarded behaves like a child who is half his or her age and needs to be shown serveral times how to do an activity or task. Use simple language in working with these children and break down activities into small parts.

- **Severe Retardation -** These children require assistance with all of their daily needs. Many children will have special problems with movement and feeding and will require the assistance of an occupational therapist or a staff member trained to work with the child's individual needs.

Causes of Mental Retardation:

- o illnesss or infection
- o injury during pregnancy
- o injury during the birth process
- o genetic factors
- o sometimes the specific cause is unknown

Muscle Tone - Firmness of muscles, if the muscles are considered floppy, it means the muscles are weak or loose. Muscles may also be rigid or stiff.

Muscular Dystrophy - Progressive degeneration of the muscles that are used for moving and maintaining posture. This is usually, but not always, an inherited condition. The muscles that are affected, the rate at which the muscles are destroyed and the type of dystrophy the child has determines how long a child with Muscular Dystrophy will live. There is no known cure or treatment for this disease.

Orientation and Mobility Training - Training for children with a visual loss which enables them to move about safely and indepently, as well as having the ability to freely experience the world around them. Blind children are taught how to protect their bodies in independent movement and to function without the assistance of others.

Sign Language - Communicating by using specific hand movements that have a particular meaning.

Special Education - Edcational programs provided to children with developmental disabilities which address specific areas in which the child may be developmentally delayed, as well as providing instruction in academics.

Types of special education programs include:

- o **Integrated Classroom -** Usually offer a special class for a specific problem in a regular school. The children are in this class for only part of the day and will join other students for some school subjects. For example, a child

who is mentally retarded may attend a "special class" for academics, but join other students without disabilities for art, physical education shop or music.

- o Itinerant Programs - Will serve a child with a special need who is capable of attending a regular school program. For example, a child who is blind, however reads, writes and types in braille, will need assistance from a specialist to help secure educational materials that are in braille or transcribe necessary materials. This child attends regular school with other students and participates in most school functions and activities.

- o Segregated Schools - Children with all types of physical and mental disabilities within a given geographical area attend school in a facility which offers educational programs and services specifically designed for children with developmental disabilities.

- o Segregated Classroom - These classrooms are located within a regular elementary or secondary school and are for children who have the same or similar developmental disability. For example, children who are mentally retarded will attend a regular school, but will be in a "special class" with other children who are mentally retarded and be taught by a specially trained teacher. They will be in this class for the full day.

Spina Bifida - Is often called open spine. It occurs when the bone fails to completely enclose the spinal cord. When one or more of the bones of the spine fail to close an opening is created in the spinal column. The nerve tissue in the spinal column can then slip through this opening forming a sac that sticks out of the body. Spina Bifida is usually identified at birth and an operation can repair the sac making it less visible. However, the operation does not correct the damage that has been done to the nerves. The effects of Spina Bifida varies. The location of the opening and whether the cord comes out from it will determine the

severity of damage. Many children with Spina Bifida have average to above average intelligence and have been very successfully mainstreamed into a regular public school setting.

Cause of Spina Bifida: The cause of Spina Bifida is not known

Characteristics of mild Spina Bifida:

- o weak muscles
- o some loss of feeling in the skin

Characteristics of moderate to severe Spina Bifida may include:

- o child may be paralyzed in the legs
- o no bladder and bowel control
- o no skin sensations in the lower part of the child's body
- o possible seizures
- o learning disabilities resulting form perceptual difficulties and/or damage to the brain
- o motor difficulties in the arms and hands and possible slowness in performing certain tasks
- o some children who have Spina Bifida may also develop a condition called Hydrocephalus:

- o **Hydrocephalus** - Too much spinal fluid builds up in the brain and if left untreated the pressure from the fluid can damage the brain. However, this can be prevented by surgery that places a shunt (tube) in the child's head. The shunt directs the excess fluid away from the brain into another part of the body from which it can be eliminated.

Stabilization - Support provided to the body of a limb to help specific movement.

Task Analysis - Teaching technique which works very well with mentally retarded children. This method involves breaking down a task or an activity into small consecutive steps and teaching and practicing with the child each step until the child can complete the activity.

UCP - United Cerebral Palsy

Vision - Process that involves seeing with the eyes and interpreting what is seen with the brain.

- o **Central Acuity** - Ability of the eye to preceive the shape of objects in the direct line of vision.

Visual Acuity - The ability to see clearly.

Visual Impairment - Partial or total loss of sight. Through early intervention and the assistance of visual aids a child who has a visual impairment may lead a normal and productive life and be able to function independently of others.

Causes of Visual Impairment:

- o disease
- o illness during pregnancy
- o injury or accidents
- o defects in the shape of the eye
- o loss of functioning in various parts of the eye

Two major types of Visual Impairments are:

- o **Partial Sight -** A child is considered to have partial sight if standing at a distance of 20 feet he or she can identify the same size letter or symbol that the child with normal vision can identify at 70 feet.

- o **Blindness -** A child is considered blind if any one of the following exist: a) child is sightless or has such limited vision that he or she must rely on hearing and touch as the primary means of learning and experiencing the environment around them, b) a determination of legal blindness in the state in which the child lives has been made, and c) central acuity does not exceed 20/200 in the better eye with correcting lenses or whose visual acuity is greater than 20/200; which means that a child who is blind sees the same size letter or symbol at a distance of 20 feet that a child with normal vision would see at 200 feet.

Children may also have other visual problems which include:

- o **Color Blindness -** Inability to recognize the differences in color; usually for red or green, rarely for blue or yellow.

- o **Hyperopia -** Farsightedness; a child will have difficulty seeing items or objects at a distance.

- o **Myopia -** Nearsightedness; a child will have difficulty seeing items or objects at a distance.

- o **Strabismus** - A condition in which the eye turns or squints due to a muscle or sight disturbance. The child's eyes will look crossed.

Children with visual handicaps often display certain mannerisms. They include:

- o shifting weight from one foot to another
- o rocking their body
- o turning their head more or less rapidly
- o non-stop tapping of themselves, toy or object
- o seemingly inappropriate hand-clapping and tongue licking.

INSERVICE TRAINING GUIDES

VOLUME II

MAINSTREAMING WORKS!

RESOURCE NUMBER — TITLE

1. MANAGING MAINSTREAMING

   A. Caring for children with special needs in child care centers: Answers for Owners and Operators.

   B. Problem Solving Exercise: Classroom Placement

   C. Who Are We In This Program?

   D. Worksheet: Center Policies

   E. General Information About Handicaps

   F. Sources of Help and Information

   G. State Resource Sheet: Florida

2. WELCOMING PARENTS AS PARTNERS IN CHILD CARE

   A. Parent Communication and Involvement: Self-Assessment for Child Care Centers

   B. Understanding Parents

   C. Evening Parent Meeting Schedule

3. ADAPTING ENVIRONMENTS FOR MAINSTREAMING

   A. List of Values

   B. Criteria to Consider Before Designing an Environment

   C. Arrangement of Materials

INSERVICE TRAINING GUIDES (Continued)

RESOURCE NUMBER	TITLE
4.	**USING OUTSIDE RESOURCES TO MAKE MAINSTREAMING WORK**
A.	Making The Facility Accessible
B.	Early Intervention Is Important
C.	Sample Screening Report
D.	Sample Annual Reassessment
E.	Sample IEP
F.	The IEP: What It Is
G.	Specialists for Special Needs
5.	**PHYSICAL MANAGEMENT OF CHILDREN IN MAINSTREAMING**
A.	Lifting, Carrying, and Transferring
B.	Assisting with Eating, Dressing, and Exercising
6.	**COMMUNICATION AND MAINSTREAMING**
A.	Communication Systems
B.	What Should We Talk About?
7.	**CARING FOR CHILDREN WITH APNEA PROBLEMS USING APNEA MONITORS**
A.	Responsibility List for Apnea Monitor Users
8.	**BEHAVIOR MANAGEMENT IN MAINSTREAMING**
A.	Consistency
B.	Ignoring
C.	Stop the World
D.	Granny's Law
E.	Problem Solving: Behavior Management

INSERVICE TITLE: Managing Mainstreaming

INTENDED OUTCOME: Owners, Operators and Managers of child care centers will understand some management policies which facilitate mainstreaming.

INSTRUCTORS: Early intervention center and child care licensing personnel; or owner/operator of a mainstreamed child care center.

TIME: 2 Hours

Objectives	Activities	Resources
1. Child care personnel will review their concerns about mainstreaming children with special needs in child care centers.	Distribute Resource #1A, & lead participants through a discussion of its major points. Be sure to cover specialized centers for special needs children, required ratios for mixed handicapped & nonhandicapped children in your state, sharing costs of extra services & equipment, benefits to nonhandicapped children, size of centers, & training opportunities available in your area.	Resource #1A, "Caring for Children with Special Needs in Child Care Centers: Answers for Owners and Operators."
2. Child care owners & operators will understand that good management techniques transfer over to mainstreaming situations.	Distribute Resource #1B, Problem Solving. Lead participants through a discussion of alternative means of dealing with the presented problem.	Resource #1B, "Problem Solving Exercise: Classroom Placement."

INSERVICE TITLE: Managing Mainstreaming (Continued)

INTENDED OUTCOME: Owners, Operators and Managers of child care centers will understand some management policies which facilitate mainstreaming.

INSTRUCTORS: Early intervention center and child care licensing personnel; or owner/operator of a mainstreamed child care center.

TIME: 2 Hours

Objectives	Activities	Resources
3. Child care personnel will develop a policy about special needs children as appropriate for their own program goals & objectives.	Distribute Resource #1C, "Who Are We In This Program?" Use as a guide for completing the Policies Worksheet. Distribute Resource #1D Worksheet: Center Policies. If inservice is being offered to staff who are all from one center or agency, then guide them in completing the Worksheet together. Otherwise, allow time for individual completion.	Resource #1C, "Who Are We In This Program?" From Northwest Center Child Development Program.
4. Child care personnel will be aware of the national resources available to them as they serve children with special needs.	Distribute 3x5 cards, post-cards, or pre-stamped postcards to each participant. Then, distribute the NICHCY Resource Sheets provided. Have each participant fill out a postcard requesting information from an agency. Collect & mail the postcards.	Resources #1E, 1F, 1G, National Information Center for Handicapped Children and Youth: Resource Sheets.

INSERVICE TITLE: Welcoming Parents as Partners in Child Care

INTENDED OUTCOME: Child care personel will develop an action plan for involving parents of children with special needs in child care.

INSTRUCTORS: Early childhood educator, special educator, or developmental specialist who is experienced in working with parents. Suggestion: co-teach with the parent of a mainstreamed preschooler.

TIME: 2 Hours

Objectives	Activities	Resources
1. Child care personnel will explore their own attitudes toward parent involvement.	Administer Resource #2A, Self-Assessment. Discuss results. Be sure to allow time for personnel to discuss some of the negative, as well as the positive, consequences of parent involvement.	Resource #2A, "Parent Communication & Involvement: Self-Assessment for Child Care Centers." From S. Carnahan, IMPACT Child Care Project.

INSERVICE TITLE: Welcoming Parents as Partners in Child Care (Continued)

INTENDED OUTCOME: Child care personel will develop an action plan for involving parents of children with special needs in child care.

INSTRUCTORS: Early childhood educator, special educator, or developmental specialist who is experienced in working with parents. Suggestion: co-teach with the parent of a mainstreamed preschooler.

TIME: 2 Hours

Objectives	Activities	Resources
2. Child care personnel will understand some factors involved in working with parents of children with special needs.	On blackboard, overhead projector, or flipchart, present the list of Reactions of Parents (of Special Needs Children) found in Resource #2B. Distribute Resource #2B at the end of the discussion. Be sure to include: a. Refusing to believe there is a problem. b. Feeling angry. c. Wanting to blame someone. d. Feeling guilty. e. Looking for a cure. f. Worry & fear for the future. g. Depression. h. Accepting the situation. Lead personnel in discussing these factors as they affect parent involvement with the child care center. Be sure to discuss parent's need to be in control of their child's care, & kept informed of daily events.	Resource #2B, "Understanding Parents." From When You Care for Handicapped Children.

INSERVICE TITLE: Welcoming Parents as Partners in Child Care (Continued)

INTENDED OUTCOME: Child care personnel will develop an action plan for involving parents of children with special needs in child care.

INSTRUCTORS: Early childhood educator, special educator, or developmental specialist who is experienced in working with parents. Suggestion: co-teach with the parent of a mainstreamed preschooler.

TIME: 2 Hours

Objectives	Activities	Resources
3. Child care personnel will establish an action plan for facilitating parent involvement.	Ask each center to choose 2 activities from the survey that they are willing to initiate in their center within the next 6 months. As an example, distribute Resource #2C, Evening Parent Schedule.	Resource #2C, "Evening Parent Meeting Schedule." From Northwest Center Child Development Program.

INSERVICE TITLE: Adapting Environments for Mainstreaming

INTENDED OUTCOME: Child Care Personnel will understand ways in which environments facilitate mainstreaming.

INSTRUCTORS: Special Education, Early Childhood Education, or other teacher with classroom experience in mainstreaming.

TIME: 2 Hours

Objectives	Activities	Resources
1. Child care personnel will understand the linkages between program philosophy, values and room design.	Distribute List of Values, Resource #1. Ask child care personnel to pick out 5 values they believe are important, & that their child care center is attempting to teach. Discuss ways in which particular types of room designs foster the development of independence, cooperation, etc.	Resource #3A, "List of Values." From Values Survey by Milton Rokeach.
2. Child care personnel will understand the criteria to consider before designing an environment.	Distribute Resource #3B. With child care personnel, review the list of criteria, & draw definite conclusions in each area which are specific to their child care center. Have personnel save their lists of criteria. Distribute Resource #3C. Arrangement of Materials.	Resource #3B. "Criteria to Consider Before Designing an Environment, adapted." From Northwest Center Child Development Program. Resource #3C. "Arrangement of Materials." From Northwest Center Child Development Program.

INSERVICE TITLE: Adapting Environments for Mainstreaming

INTENDED OUTCOME: Child Care Personnel will understand ways in which environments facilitate mainstreaming.

INSTRUCTORS: Special Education, Early Childhood Education, or other teacher with classroom experience in mainstreaming.

TIME: 2 Hours

Objectives	Activities	Resources
Accessibility: Getting In The Door	1. Advise personnel of availability of Accessibility Codes & Standards for each state. Emphasize need to consider local building code whenever structural modifications are made.	(Florida Board of Building Codes & Standards, Chapter 553, Part V.)
	2. Pass out Resource #4A, & discuss use of ramps, widened doors & door thresholds in making facilities accessible to children with special needs.	Resource #4A "Making the Facility Accessible." From When You Care for Handicapped Children.

INSERVICE TITLE: Using Outside Resources to Make Mainstreaming Work

INTENDED OUTCOME: Child care personnel will be familiar with the information and services provided to special needs children in their area, and how the center can use these resources.

INSTRUCTORS: Staff member from an early intervention agency.

TIME: 2 Hours

Objectives	Activities	Resources
1. Child care personnel will understand the general objectives of early intervention agencies.	Distribute Resource #4B, & review its contents with personnel. At the same time, distribute the brochure of your local early intervention agency serving developmental delayed/ special needs children 0-5 years old and briefly review the services offered by the agency. Be sure to include information available on referral for developmental screening in your area.	Resource #4B, Early Intervention is Important.
2. Child care personnel will be aware of the written information available to them about a preschool special needs child from the early intervention agency.	Brainstorm a list of questions about a special needs child which a child care center might need to have answered. Then, distribute Resources #4C, D, E, F, and discuss their contents.	Resource #4C, Sample Screening Report. Resource #4D, Sample Annual Reassessment. Resource #4E, Sample IEP. Resource #4F, The IEP: What It Is. From FDLRS, "Training Manual for Exceptional Student Aides."

INSERVICE TITLE: Using Outside Resources to Make Mainstreaming Work (Continued)

INTENDED OUTCOME: Child care personnel will be familiar with the information and services provided to special needs children in their area, and how the center can use these resources.

INSTRUCTORS: Staff member from an early intervention agency.

TIME: 2 Hours

Objectives	Activities	Resources
3. Child care personnel will be familiar with the services provided by ancillary professionals to children with special needs.	Using Resources provided, review the services, roles, and contributions of occupational, physical, & speech therapies.	Resource #4G. Specialists for Special Needs. From Headstart Mainstreaming Preschoolers series.

INSERVICE TITLE: Physical Management of Children in Mainstreaming

INTENDED OUTCOME: Child care personnel will understand principles of physical management of children with special needs.

INSTRUCTORS: PT, OT, or qualified Exceptional Student Education professional.

A. LIFTING, CARRYING, AND TRANSFERRING

TIME: 2 Hours

Objectives	Activities	Resources
1. Child care personnel will demonstrate competency in basic techniques of lifting, carrying, and transferring young children with special needs.	Lead all personnel through a discussion of proper techniques of lifting, carrying and transferring young children with special needs, using Resource #5A. Separate personnel into small groups of 2 or 3, and lead each group through practice of: a) lifting a heavy child b) assisting a child to walk during change of position c) assisting a child who has lost his balance d) walking down stairs e) horizontal lifting f) transfer g) carrying	Resource #5A, "Lifting, Carrying and Transferring." From Training Manual for Exceptional Student Aides. Produced by the Florida Diagnostic Learning Resource System.

INSERVICE TITLE: Physical Management of Children in Mainstreaming (Continued)

INTENDED OUTCOME: Child care personnel will understand principles of physical management of children with special needs.

INSTRUCTORS: PT, OT, or qualified ESE professional.

B. ASSISTING THE SPECIAL NEEDS CHILD IN THE CLASSROOM

TIME: 1 Hour

Objectives	Activities	Resources
2. Child care personnel will understand general guidelines for assisting the handicapped child when eating, dressing, and exercising.	Lead all personnel through a discussion of proper techniques of assisting with eating, dressing, and exercising, using Resource #5B. Using young children as partners, demonstrate appropriate techniques. Using other adults to demonstrate assisting with dressing and exercising is acceptable, but any demonstration of feeding techniques must be done using children as partners. Tailor presentation of feeding techniques to meet the needs of the children in the particular center you are helping.	Resource #5B. "Assisting with Eating, Dressing, and Exercising." From Training Manual for Exceptional Student Aides.

INSERVICE TITLE: Communication and Mainstreaming

INTENDED OUTCOME: Child care personnel will be introduced to the concept of communication programs, and to basic, functional signs.

INSTRUCTORS: Exceptional Student & Educational Teacher, Speech Pathologist, or other qualified person. Must be able to use sign language as needed in module.

TIME: 1-2 Hours

Objectives	Activities	Resources
1. Child care personnel will understand that there are several ways in which children with hearing impairments or communication disorders are taught to communicate.	Distribute Resource #6A, "Communication Systems," & explain or demonstrate oral, sign language, finger spelling, & total communication approaches. Emphasize: ° The importance of having at least one person in the child's room who is committed to learning the child's system of communication. ° The importance of using the communication system chosen by the child's parents, & of reinforcing learning taking place at home.	Resource #6A, Communication Systems. From Headstart Main-Streaming Preschoolers Series: Children with Hearing Impairment.

INSERVICE TITLE: Communication and Mainstreaming (Continued)

INTENDED OUTCOME: Child care personnel will be introduced to the concept of communication programs, and to basic, functional signs.

INSTRUCTORS: Exceptional Student & Educational Teacher, Speech Pathologist, or other qualified person. Must be able to use sign language as needed in module.

TIME: 1-2 Hours

Objectives	Activities	Resources
2. Child care personnel will identify the specific ways in which they can communicate about basic needs with a hearing or speech impaired child.	Distribute Resource #6B, "What Should We Talk About?" ° If inservice training is to benefit a particular child placed in a child care center, then individualize the resource list to arrive at a functional in-class vocabulary for that child. ° If inservice training is more general, then introduce basic signs for the areas covered, & work with staff until they are proficient. You may wish to include pictures of signs.	Resource #6B, "What Should We Talk About?"

INSERVICE TITLE: Caring for Children with Apnea Problems using Apnea Monitors

INTENDED OUTCOME: Child care personnel will complete training in use of Apnea Monitors in child care centers.

INSTRUCTORS: Module must be taught by a registered nurse or respiration therapist, who has attended and successfully completed the HRS Childrens' Medical Service HEALTHDYNE workshop on Apnea Monitoring.

TIME: 2 Hours, plus CPR Course

Objectives	Activities	Resources
1. Child care personnel will show an increase in their knowledge of the facts about children with apnea problems.	Getting the facts: In Lecture/Discussion format present the basic facts about apnea problems in children. Be sure to include incidence, duration, effect on development, and effect on family systems.	To be provided by HRS/CMS or Healthdyne: * Monitoring handbook for us in child care center. * Infant Monitor Model 16900 Manufacturers Sheet. * Healthdyne/CMS contact packet.
2. Child care personnel will demonstrate the application of knowledge about apnea monitoring.	Lead group through hands on practice with monitor and accessories, using a doll. a. Proper placement of electrodes/belt. b. Recognition of alarms/ responses. c. Review of safety factors involved in apnea monitoring.	Resource #7A, "Responsibility List for Apnea Monitor Users." From Healthdyne, Inc.
3. Child care personnel will know where to go locally for additional help in providing services for children with apnea problems.	Familiarize personnel with local resources, including private physicans, Childrens' Medical Service contact, Healthex/ Healthdyne contact, and the local SIDS (Sudden Infant Death Syndrome) Chapter.	

INSERVICE TITLE: Caring for Children with Apnea Problems using Apnea Monitors (Continued)

INTENDED OUTCOME: Child care personnel will complete training in use of Apnea Monitors in child care centers.

INSTRUCTORS: Module must be taught by a registered nurse or respiration therapist, who has attended and successfully completed the HRS Childrens' Medical Service HEALTHDYNE workshop on Apnea Monitoring.

TIME: 2 Hours, plus CPR Course

Objectives	Activities	Resources
4. Child care personnel will attend & successfully complete a course in CPR.	Suggested: American Red Cross Race for Life, a 4-hr. course in 1 rescuer CPR.	

INSERVICE TITLE: Behavior Management and Mainstreaming

INTENDED OUTCOME: Child Care personnel will understand that good behavior management techniques work for all children.

INSTRUCTORS: Teacher, psychologist, or social worker who is experienced in managing children's behavior in a classroom or other group setting.

TIME: 2 Hours

Objectives	Activities	Resources
1. Child care personnel will review several basic behavior management techniques.	Distribute Resources #8A, B, C, D, Consistency, Ignoring, Stop the World, and Granny's Law. Allow time for personnel to review them. Discuss their relationship to principles of reinforcement. Point out the non-intrusive nature of these management techniques, and emphasize that Time Out is a last-resort technique.	Resources #8A, B, C, D, Consistency, Ignoring, Stop the World, from Mendota Mental Health Institute Home and Community Treatment Program. Granny's Law, from Lee Mental Health Center Parent Education Program.
2. Child care personnel will discuss the application of behavior management techniques in the child care sitting where children with special needs are included.	Distribute Resource #8E, Problem Solving Exercises: Behavior Management. Lead personnel through application of behavior management techniques to the scenarios, as indicated. You may choose to separate personnel into small groups and assign each group a scenario, or discuss each with the group as a whole.	Resource #8E, Problem Solving Exercises: Behavior Management.

PROBLEM SOLVING EXERCISE: Classroom Placement

You are the owner or operator of a child care center.

A classroom teacher has had John, a blind 3-year old boy, in her classroom for three months. The teacher, Mrs. Smith, welcomed John, and has been very cooperative in all parent and administrator meetings. Several concrete suggestions for John's care have been made to Mrs. Smith, and she appears to be very receptive to them.

The early intervention specialist who works with John one-hour a week drops by to talk with another child, and observes John through the one-way mirror in Mrs. Smith's room. The specialist comes to you, very concerned. She reports: John's teacher feeds him most of his lunch, although John feeds himself (slowly) at home; John's teacher still holds his hand when they change activities in the room; and when the other children are engaged in primarily visual play, like coloring, John is allowed to put his head down and rub his eyes, rather than being given a substitute activity.

It is evident that John's teacher is not carrying through on classroom suggestions -- even simple ones, which require little work, like encouraging independence.

You stop Mrs. Smith in the hall and ask why she fed John his lunch. Mrs. Smith replies that John makes a mess when he eats, and that she feels sorry for John, who eats so slowly. Mrs. Smith is afraid that others will make fun of John, although they haven't yet.

WHAT WILL YOU DO NEXT?

Check suggestions you'd try first, then check a second choice.

There are no right or wrong answers.
We are exploring alternatives for action.

a. Confront Mrs. Smith directly and tell her that you suspect her pity is getting in the way of John's successful mainstreaming, and you are concerned about this and would like to find a solution.

Resource #1B

Problem Solving: Classroom Placement

WHAT WILL YOU DO NEXT? (Continued)

b. Let it go for another month. You don't want to put the teacher on the defensive, as she seems to be doing her best.

c. Try to smooth things over by offering to buy special toys for John.

d. Tell the teacher that if she will agree to try more of the suggestions with John, you will get her extra help at mealtimes.

e. Observe John yourself for an hour, without telling Mrs. Smith why.

f. See if you could arrange for more intensive training for Mrs. Smith, like having a specialized co-teacher come in her room for one hour a day for one week.

g. Move John to another class and start over.

h. Other:

WHO ARE WE IN THIS PROGRAM?

Overall Philosophy

It is the philosophy of this program to provide developmentally appropriate experiences, therapeutic intervention when needed and parent involvement options in order to meet the needs of the children and families who seek services in this program.

Educational Philosophy

For the children, we emphasize a cognitive-developmental approach. It is this program's intention to express, through the environment, the usefulness of independent problem solving skills and self-initiated learning through exploration.

Children will be provided services without regard to race, color, creed, national origin, or handicapping condition.

What Is Integrated Programming?

Integration, simply stated, is having normally developing children, and children with handicapping conditions, learn in the same environment. It is attending to the needs of all children in the same program. It is valuing each child as a unique individual within a group.

There are some very good reasons for doing this. You, as a parent who has decided this program is a valuable place for your child to attend will want to know some of the reasons.

By offering children this early opportunity to learn about other children's likenesses and differences, we are providing them the opportunity to develop positive attitudes toward all people. Young children learn by the nurturing and caring people who interact with them each day.

Resource #1C

Who Are We In This Program? From Northwest Center Child Development Program.

How Will Integrated Programming Enhance The Child's Learning Environment Each Day?

Children will have the opportunity to develop skills while working and playing side by side. Sometimes they learn while watching a friend. They have time to practice new skills. Children can learn appropriate and important socializing skills, with a carefully woven structure. They learn to share and care for materials and one another.

There is communication and language development for each child through interaction with others. Physical activities, appropriate to each child, encourage development of the child's body. Staff persons with special skills help children to become aware of the opportunity to learn from each child and that each child has something special to offer to someone.

Here Are Some Program Goals That Develop From Our Program Philosophy:

Each child will have an individual program plan that serves as a guide to the parents. This guide will help parents to know what their child is involved in each day and what teachers and therapists will be doing with the child. This program plan comes after the initial assessments are conducted, because this information provides parents and staff persons with the information about how each child's rate of development is occurring in some basic areas (large muscles, small muscles, commuication, social skills, self-help and cognitive).

Each child is unique within his/her own family unit. Families come in all arrangements, so a program arrangement needs to fit each family. That means that a family might have an incenter placement, to accommodate the parent(s) who work outside of the home. A family with a child who has a handicapping condition may choose to have a homebased program, or a combination homebased and incenter program. Child and family needs change. We seek to be sensitive to those needs.

It is a goal of this program to include parenting persons in whatever way fits with their life style and in a variety of ways that make parents feel involved with their child's everyday activities.

It is a goal to assist parents in making decisions about what is the best arrangement for their child when it is time to leave this program.

WORKSHEET: CENTER POLICIES

Directions: Using the guide provided, fill out this worksheet to arrive at an accurate picture of your center's programming philosophy.

Overall Philosophy

It is the philosophy of this program to:

We serve all children, or serve children with the following restrictions:

We want to support the following values:

Educational Philosophy

We primarily emphasize education in these domains:

Our educational strengths are:

We wish to train children who will:

Our policy towards children with special developmental needs is:

Program Goals, Which Develop From Overall Philosophy:

Our policy Towards Parent Involvement Is:

Resource #1D

Worksheet: Center Policies

NATIONAL INFORMATION CENTER FOR HANDICAPPED CHILDREN AND YOUTH
P.O. BOX 1492 WASHINGTON, D.C. 20013

General Information About Handicaps and People with Handicaps

Definition

The regulations for Public Law 94-142 (The Education for All Handicapped Children Act) list 11 types of handicaps:

1. DEAF
   A hearing impairment so severe that the child is impaired in receiving linguistic information through hearing, with or without amplification.
2. DEAF-BLIND
   Simultaneous hearing and visual impairments, whose combination causes such severe communication and other developmental and educational problems that the child cannot be accommodated in special education programs designed soley for deaf children or blind children.
3. HARD OF HEARING
   A hearing impairment, whether permanent or fluctuating, which is less severe than the definition of "deaf" in this section.
4. MENTALLY RETARDED
   Below average general intellectual functioning existing along with deficits in adaptive behavior and manifested during the developmental period.
5. MULTIHANDICAPPED
   Several simultaneous impairments (such as mental retardation and blindness; mental retardation and orthopedic impairments; and so forth), the combination of which causes such severe educational problems that the child cannot be accommodated in special education programs designed solely for one of the impairments. (This definition does not include a deaf-blind child.)
6. ORTHOPEDICALLY IMPAIRED
   A severe orthopedic impairment, including an impairment caused by a birth defect (e.g., clubfoot, absence of an extremity), an impairment caused by disease (e.g., poliomyelitis, bone tuberculosis), and impairment from any other cause (e.g., cerebral palsy, amputations, and fractures or burns which cause contractures).
7. OTHER HEALTH IMPAIRED
   An autistic condition manifested by severe communication and other developmental and educational problems; or limited strength, vitality, or alertness, due to chronic or acute health problems such as heart condition, tuberculosis, rheumatic fever, nephritis, asthma, sickle cell anemia, hemophilia, epilepsy, lead poisoning, leukemia, or diabetes.
8. SERIOUSLY EMOTIONALLY DISTURBED
   A condition in which the individual exhibits one or more of the following characteristics over a long period of time and to a marked degree: An inability to learn which cannot be explained by intellectual, sensory, or health factors; an inability to build or maintain satisfactory interpersonal relationships with peers and teachers; inappropriate behavior or feelings under normal circumstances; a general pervasive mood of unhappiness or depression; or a tendency to develop physical symptoms or fears associated with personal or school problems. (This definition includes children who are schizophrenic.)
9. SPECIFIC LEARNING DISABILITY
   A disorder of one or more of the basic psychological processes involved in understanding or in using language, spoken or written, which may manifest itself in an imperfect ability to listen, think, speak, read, write, spell, or to do mathematical calculations. The term includes such conditions as perceptual handicap, brain injury, minimal brain dysfunction, dyslexia, and developmental aphasia. The term does not include a learning problem which is primarily the result of a visual, hearing, or motor handicap, of mental retardation, or of environmental, cultural, or economic disadvantage.
10. SPEECH IMPAIRED
    A communication disorder, such as stuttering, impaired articulation, a language impairment, or a voice impairment.
11. VISUALLY HANDICAPPED
    A visual impairment, with or without correction. The definition includes both partially sighted children and blind children.

Prevalance

In the school year 1981-82, over 4.2 million children received special education and related services in public schools.

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Zukerman, L. & Yura, M. T. *Raising The Exceptional Child: Meeting the Everyday Challenge of the Handicapped or Retarded Child*. 1979 (Hawthorn Books, 2 Park Avenue, New York, NY 10016)

Resources

Alexander Graham Bell Association for the Deaf
3417 Volta Place, N.W.
Washington, D.C. 20007

American Coalition of Citizens with Disabilities
1200 15th Street, N.W.
Washington, DC 20036

American Council for the Blind
1211 Connecticut Avenue, N.W.
Suite 506
Washington, DC 20036

American Federation for the Blind
15 West 16th Street
New York, NY 10011

American Speech-Language-Hearing Association
10801 Rockville Pike
Rockville, MD 20852

Association for Children and Adults with Learning Disabilities
4156 Library Road
Pittsburgh, PA 15234

Association for Persons with Severe Handicaps
7010 Roosevelt Way, N.E.
Seattle, WA 98115

Association for Retarded Citizens/U.S. National Headquarters
P.O. Box 6109
2501 Avenue J
Arlington, TX 76011

Association for the Care of Children's Health
3615 Wisconsin Avenue
Washington, DC 20016

Council for Exceptional Children
1920 Association Drive
Reston, VA 22091

Down's Syndrome Congress
1640 West Roosevelt Road
Chicago, IL 60608

Epilepsy Foundation of America
4351 Garden City Drive
Landover, MD 20785

Goodwill Industries of America
9200 Wisconsin Avenue, N.W.
Bethesda, MD 20814

March of Dimes Birth Defects Foundation
1275 Mamaroneck Avenue
White Plains, NY 10605

Mental Health Association
1800 North Kent Street
Arlington, VA 22209

National Association of the Deaf
814 Thayer Avenue
Silver Springs, MD 20910

National Easter Seal Society
2023 West Ogden Avenue
Chicago, IL 60612

National Society for Children and Adults with Autism
1234 Massachusetts Avenue, N.W.
Suite 1017
Washington, DC 20005

National Spinal Cord Injury Association
369 Elliot Street
Newton Upper Falls, MA 02164

Spina Bifida Association of America
343 South Dearborn Street
Suite 319
Chicago, IL 60604

United Cerebral Palsy Association
666 East 34th Street
New York, NY 10016

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National Information Center for Handicapped Children and Youth

P.O. BOX 1492
WASHINGTON, D.C. 20013

SOURCES OF HELP AND INFORMATION

There are a number of sources for more information on handicaps and related issues. This section describes some of the things you can have sent to you.

DISABLED USA

President's Committee on Employment of the Handicapped
Washington, D.C. 20210.
(Published Monthly)

Reports progress in opportunities for people with disabilities and developments in rehabilitation and employment.

THE INDEPENDENT

Center for Independent Living,
2539 Telegraph Avenue
Berkeley, CA 94704
(Published quarterly)

Articles about disabilities and up-to-date information on independent living.

REPORT

The National Center for a Barrier Free Environment
1015 15th Street, N.W. Suite 700
Washington, DC 20005
(Published bi-monthly)

News about legislation related to accessibility, news briefs and summaries of articles and books mainly concerned with barriers.

SIBLING INFORMATION NETWORK NEWSLETTER

Department of Educational Psychology
Box U-64
University of Connecticut
Storrs, CT 06268

Research and literature reviews, meetings, family relationship information of interest to siblings of youth with handicaps.

THE EXCEPTIONAL PARENT

The Exceptional Parent
296 Boylston Street
3rd Floor
Boston, MA 02116
(Published eight times yearly)

Emphasis on education, diagnosis, attitudes, care; covering all handicaps, it is directed toward parents.

THE GREEN SOURCE BOOK -- NATIONAL DIRECTORY OF PRODUCTS AND SERVICES FOR THE DISABLED (Formerly entitled GREEN PAGES)

Source Book Publications
P.O. Box 1586
Winter Park, FL 32789
(Published annually)

Annual Directory of products and services. Subscription includes an occasional newsletter, "Green Papers," with legislative information and stories about people with handicaps.

UPFRONT

Mafex Associates, Inc.
90 Cherry Street, Box 519
Johnstown, PA 15907
(Published 11 times a year)

A newspaper for and about physically and mentally disabled people.

INFORMATION ABOUT HANDICAPPING CONDITIONS

Write to these agencies for information about all handicapping conditions. Specify exactly what you are interested in. Organizations dealing with specific handicapping conditions are listed on individual fact sheets.

American Civil Liberties Union
132 West 43rd Street
New York, NY 10036

American Genetics Association
818 18th Street, NW
Washington, DC 20036

Council for Exceptional Children
1920 Association Drive
Reston, VA 22091

Developmental Disabilitites Office
U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 338E
Washington, DC 20201

Human Resources Center
I.U. Willets Road
Albertson, NY 11507

Library of Congress
Division for Blind and Physically Handicapped
1291 Taylor Street, NW
Washington, DC 20542

National Easter Seal Society
2023 West Ogden Avenue
Chicago, IL 60612

National Rehabilitation Association
633 South Washington Street
Alexandria, VA 22314

Office for Handicapped Individuals
U.S. Department of Health and Human Services
200 Independence Avenue, SW
Washington, DC 20201

Office of Rehabilitation Services
U.S. Department of Education
Switzer Building
330 "C" Street, SW
Washington, DC 20202

President's Committee on Employment of the Handicapped
Washington, DC 20010

President's Committee on Mental Retardation
Washington, DC 20201

Special Education Programs
U. S. Department of Education
Switzer Building
330 "C" Street, SW
Washington, DC 20202

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NICHCY
NATIONAL INFORMATION CENTER FOR HANDICAPPED CHILDREN AND YOUTH
P O BOX 1492 WASHINGTON D C 20013

STATE RESOURCE SHEET: Florida

STATE DEPARTMENT OF EDUCATION

Dr. Wendy Cullar, Bureau Chief
Bureau of Education for
Exceptional Students
Dept. of Education
Knott Building
Tallahassee, FL 32301
(904) 488-1570

Ms. Gloria Dixon Miller
Program Specialist, Prekindergarten
Exceptional Program
Dept. of Education
Knott Building
Tallahassee, FL 32301
(904) 488-2054

STATE VOCATIONAL REHABILITATION AGENCY

Lani Deauville, Dir.
Office of Voc. Rehab.
Dept. of Health & Rehab. Svcs.
1309 Winewood Boulevard
Tallahassee, FL 32301
(904) 488-6210

OFFICE OF STATE COORDINATOR OF VOCATIONAL EDUCATION FOR HANDICAPPED STUDENTS

William Wargo, Coord.
Handicapped & Workstudy Program
Div. of Voc. Education
Dept. of Education
Knott Building
Tallahassee, FL 32301
(904) 488-5965

STATE MENTAL HEALTH AGENCY

Stephen Hill, Ph.D.
Mental Health Program Staff Dir.
Dept. of Health & Rehab. Svcs.
1317 Winewood Blvd.
Tallahassee, FL 32301
(904) 488-8304

Chip Carbone
Program Administrator
Alcohol, Drug Abuse & Mental
Health Program - Childrens Section
Dept. of Health & Rehab. Svcs.
1317 Winewood Blvd.
Tallahassee, FL 32301
(904) 487-2415

STATE MENTAL RETARDATION PROGRAM

Susan Sharpe, Dir.
Developmental Svcs. Prog.
Dept. of Health & Rehab. Svcs.
1311 Winewood Blvd.
Building 5, Room 215
Tallahassee, FL 32301
(904) 488-4257

STATE DEVELOPMENTAL DISABILITIES PROGRAM

Joseph Kreiger, Administrator
Developmental Disabilities Council
1311 Winewood Blvd.
Building 1, Room 308
Tallahasse, FL 32301
(904) 488-4180

PROTECTION AND ADVOCACY AGENCY

Jonathan P. Rossman, Dir.
Governor's Comm. on Advocacy
for Persons with Disabilities
Clifton Bldg., Room 209
2661 Exec. Center Circle, W.
Tallahassee, FL 32301
(904) 488-9070
(1-800) 342-0823

CLIENT ASSISTANCE PROGRAM

See Protection and Advocacy Agency

PARENT COMMUNICATION AND INVOLVEMENT

Self-Assessment for Child Care Centers

Few people would not agree that parents should be involved in all aspects of their children's lives, including their day at the child care center. But, what do we mean by parent involvement? How firmly do we believe in its importance? Our efforts to encourage it can vary, from the cooperative nursery where parents routinely volunteer time as caregivers or groundskeepers, to the preschool where parents drop their children off at a main desk and have no direct contact with caregivers except by appointment.

This simple self-assessment checklist has two purposes:

1. To help you uncover your own attitudes about parent involvement.

2. To help you identify you center's strengths and suggest ways to improve communication with parents.

DIRECTIONS:

For each area of parent-center communication, rate your center with a 0, 1, or 2. Then, add up your overall score.

0 = Never done at our center.
1 = Done occasionally, 1-2 times a year, or for special events, or only for some age groups.
2 = Done routinely, as a matter of policy, frequently.

	CIRCLE ONE		
DIRECT CONTACT			
Notes sent home with children several times a week.	0	1	2
School work sent home with children.	0	1	2
Parents talk with child's caregiver daily.	0	1	2
Parents have direct contact with child's own caregiver daily.	0	1	2
Parents can drop in & visit child's classroom, any time.	0	1	2
Parents can observe classroom through one-way mirrors.	0	1	2
Specific activities, such as song sheets or games, are sent home with children.	0	1	2

PARENT COMMUNICATION AND INVOLVEMENT

Self-Assessment for Child Care Centers
(continued)

	CIRCLE ONE
FORMAL CONTACT	
Parents receive regularly scheduled "report cards" from the Center.	0 1 2
Parent-teacher conferences are scheduled by the school on a regular basis. (Score '0' if conferences available, but only if parent initiates.)	0 1 2
Bulletin board with useful information prominently displayed, changed frequently.	0 1 2
Center has a Parent Advisory Board, or parents on the Board of Directors.	0 1 2
Center provides written information on policies, curriculum, and philosophy to parents routinely.	0 1 2
PARENT-TO-PARENT CONTACT	
Each room has a "room parent" to help the teacher.	0 1 2
Lists of children in each class are available to parents; Center includes a release of information form in enrollment packette to facilitate this exchange.	0 1 2
Parents are encouraged to help with holiday parties, or to collect craft materials for the Center.	0 1 2
Center has in-room open house, where parents have an opportunity to meet each other.	0 1 2
Center has mother's/father's days, or holiday parties where parents and children attend together.	0 1 2
Center has a meeting area where parents are actively encouraged to linger and talk at drop off and pickup times.	0 1 2

PARENT COMMUNICATION AND INVOLVEMENT

Self-Assessment for Child Care Centers
(continued)

	CIRCLE ONE
SERVICE TO PARENTS	
Center provides developmental screening and/or referral information for children with physical or behavioral problems.	0 1 2
Center arranges for administration of prescription medications during the day.	0 1 2
Center provides seminars or training sessions for parents.	0 1 2
Center seeks (or cooperates with) outside professional help for children with developmental disabilities	0 1 2
Center provides group insurance, discounted supplies, or similar services to parents on a regular basis.	0 1 2

K E Y

for

PARENT COMMUNICATION AND INVOLVEMENT

Self-Assessment for Child Care Centers

(continued)

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0 - 10	You take care of children, but not parents! Significant need for improvement.
11 - 22	Better and better. You make a real effort to include parents in most aspects of child care.
23 - 33	You really work at parent involvement, and I'll bet if shows in staff and parent relationships.
34 +	A model center, doing everything possible to involve parents.

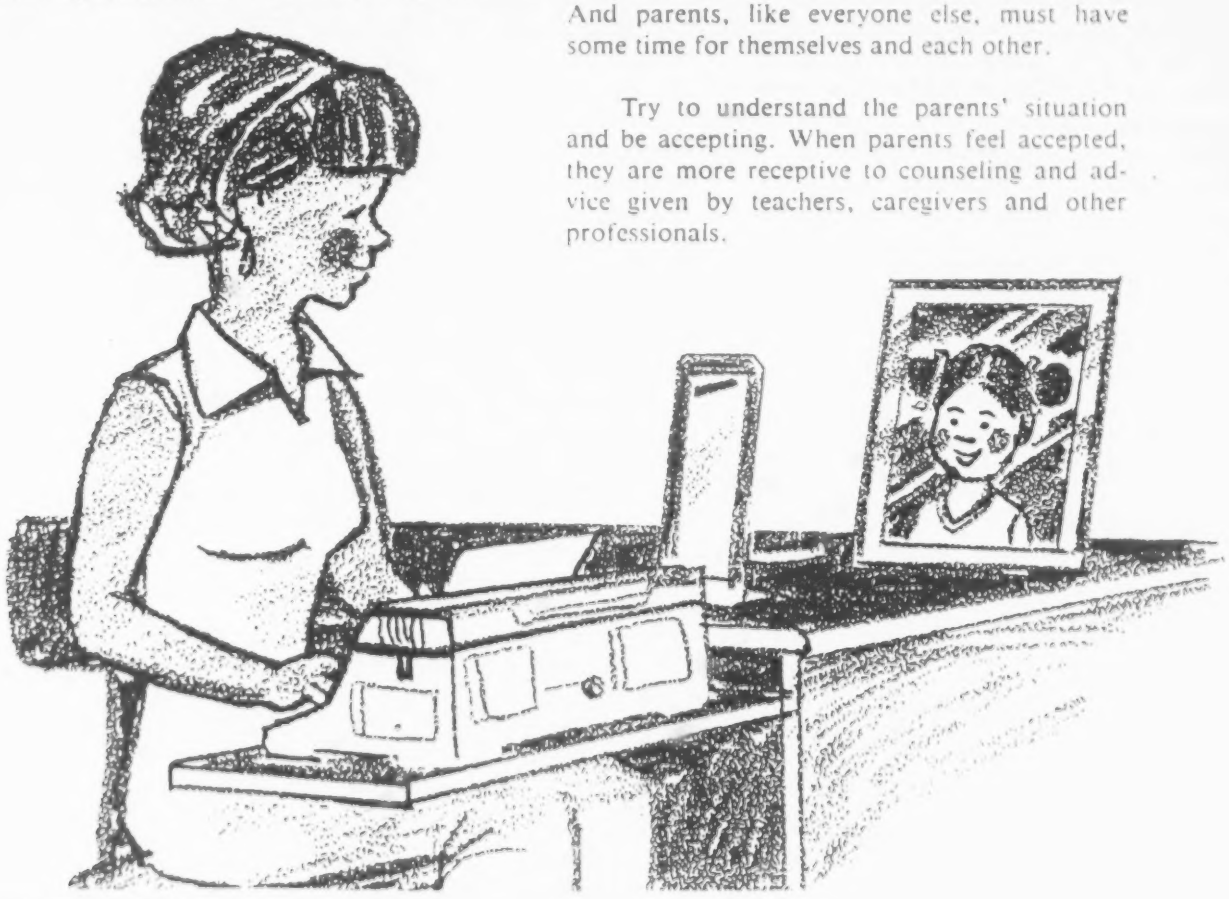
UNDERSTANDING PARENTS

When a child is handicapped it is important to understand some of the feelings or reactions of parents in order to work with them more effectively. The feelings and attitudes of parents, their acceptance of the child's condition, the way they act, and the things they say will have a strong influence on the child. Remember that each parent is an individual with concerns and ideas about the child's condition and special care needs. You can help enormously by being aware of and accepting these feelings and by listening to the parents as much as possible.

Besides considering the parents' feelings, try to remember that they have other obligations and responsibilities. If you feel they are neglecting their handicapped child, try to consider the other demands upon their time. Perhaps the mother works. There may be only one parent in the family. A handicapped child creates a financial strain. For instance, a child with an illness such as cystic fibrosis may take more than 40 pills a day; the cost of drugs, equipment, clinic, laboratory, physician fees, and hospitalization can run up to $5,000 or more a year.

Spending time with other sons and daughters can be a problem for parents of handicapped children. Sometimes a handicapped child requires so much of the parents' time for basic care, that brothers and sisters develop emotional problems of their own. They may show anger, embarrassment, guilt and grief—or even worse, they may hide these feelings. Parents may have their hands full trying to balance their duties and divide their time fairly. And parents, like everyone else, must have some time for themselves and each other.

Try to understand the parents' situation and be accepting. When parents feel accepted, they are more receptive to counseling and advice given by teachers, caregivers and other professionals.



Resource #2B, Understanding Parents.
From When You Care For Handicapped Children.

Parents' Feelings

Parents' feelings will be different depending on the nature of the child's problem. If a child merely needs glasses, the parents' only concern may be financial. "Where will I get the money to pay for this?" Some kinds of problems are harder to talk about than others, however. For example, a request for permission for testing or a suggestion that a child may need special services are more serious matters. For some parents your request may be the first indication that all is not going well for their child. Other parents may already be aware of a disability that affects their child's learning.

Let's consider some of the feelings parents of a child with a disability may experience, why they may feel this way, and how you, their child's caregiver, can help them.

1. Refusing to believe there is a problem. When it is suggested that their child may have a problem, most parents do not want to believe it, even though they may have suspected it already. This does not mean they think you are not doing your job well, or that you do not know anything about children, though some of them may say these things. What it really means is that they wish very much that the problem would go away.

What can you do? First, listen carefully. The parents may be right. There may be a reason for the child's lack of progress which you do not know about. Then tell the parents specifically what the child does that concerns you, stating facts, not opinions. For example, do say, "Robert has difficulty following directions." Do not say: "I think Robert is deaf" or "I think he is retarded."

If parents do not recognize a problem that is clear to you, you may want to ask them to visit the center or day home for an hour or two. This way they can observe their child with other children and in the same situation as you see the child. This should make it easier for you to talk with them about the child's problem. Sometimes parents do not understand why you are concerned about their child's lack of ability to do something. They may say, "But Ken is only five, why should he know his colors?" Giving the parents information about basic child development and letting them observe in the center or day home may help parents understand your concern.

2. Feeling angry. When you talk to the parents about trouble their child is having, they may become angry. They may take the problem personally and say something like, "Why does this have to happen to me?" Or a parent may become angry with you, saying things like, "Why are you picking on my child?" This is hard to deal with, and it is difficult not to become upset with someone who is angry with you.

Remember that the parents are angry because they **care** about their child. If they did not care, they would not bother to get angry. Even if they are angry with you, at the moment, it is probably only because you are there; they are hurt and upset, and anger is their reaction.

What can you do? Stay calm, and do not let your feelings be hurt. Angry parents who are trying to do the best they can for their child may not care whether they hurt your feelings. Assure them that you are trying to find ways to help the child and would welcome suggestions from them. Ask them to visit and see their child with the other children. Ask them to think of ways to help you work with the child. If you stay calm and friendly, the parents' anger will probably not last long. Let them know you respect them and their opinions and that you want to help their child.

3. Wanting to blame someone. When something happens, most people ask "Why?" Parents are no different. They want to know why their child is having trouble learning or getting along with others. Sometimes, parents who have just learned about their child's disability and those who have known but have difficulty accepting the problem, keep looking for something or someone to blame. Sometimes they blame each other or a grandparent. Sometimes they blame the school or the teacher.

How can you talk to them about this? Again, be ready to listen. The parents may tell you things about the child which can help you. For instance, they might say, "The other children make Johnny get too excited. His father never let him play with lots of kids." While you may feel this is not the reason for Johnny's excessive activity and misbehavior, it gives you a place to start. Try helping the child learn to work in a small group, and then discuss the results with the parents. It does not help to argue with parents or to point out why their reasons are not sufficient to explain the problem.

Listen to all the reasons they may give, but try to help them understand that your main interest is not in **why** the child is having trouble, but in **how to** overcome it. Ask for their suggestions on other ways of working with their child.

4. Feeling guilty. Sometimes when you discuss a child's problem with parents, they may react as if you are accusing them of being bad parents. Many parents feel that if their child has some kind of trouble, especially when behavior is a problem, they are the ones at fault. Some parents may be so upset, feeling they have "raised their child wrong," that it is hard for them to see any way to help the child.

Many children are handicapped because of conditions before or during birth. Frequently parents, especially mothers, feel they are somehow responsible for their child's disability. They may feel this way even though the cause of the condition is unknown, or even though the doctor has told them they did nothing to cause the problem. Sometimes religious beliefs may lead parents to feel the child is suffering because of something they have done.

What can you say to parents who feel guilty? Be patient and do not argue with them. Sometimes it takes a long time for people to learn to deal with difficult situations. Assure them you know they are doing their best for the child. In many cases, no one knows for sure what really causes a birth defect; there are many possible causes for almost every disability. Listen to the parents and be sure you do not sound as though you blame them for the child's problems. Instead, focus on finding ways to help the child learn in spite of a disability.

5. Looking for a cure. You may find that some parents of handicapped children always seem to be looking for a cure. When you consider that the parents care very much for their children and are very concerned for their future, it is easy to understand their actions. For some parents, it may seem that if they stop looking for a cure, they will be giving up. Sometimes they will go from doctor to doctor; sometimes they will transfer their child from program to program.

When you talk to parents who are searching for something to make their child well, they will probably not be willing to listen if you tell them there is no magic cure. What you **can** say is that until some other solution to the problem is discovered, you want to find the best possible way to help the child learn. Give them things to do at home with the child so they can help and see their child progress.

6. Worry and fear for the future. All parents have plans and hopes for their children. In many cases, when parents find out their child has a disability which affects learning, they worry about what effect this will have as the child goes through school. In serious cases, parents worry about whether their child will be able to live at home or will have to go to a special school.

When parents talk about these things with you, they may ask if you think their child will be able to succeed in this program or even go on to public school. Usually, you will not be able to answer their questions, because the

child's future is uncertain. Remember the parents are asking you this because they are worried. You can help by telling them of the progress the child is making now. Emphasize the things the child **can** do. Help the parents focus on the child's present stage of development and the activities that will help the child progress to the next stage. However, be sure that you do not make promises that cannot be kept, even though the parents might feel better at the moment. This only causes future disappointment.

Sometimes parents seem to worry about everything their child does. Many times something that concerns them is normal for children the age of their child. For instance, a parent may be quite upset when his two-year-old shouts "No!" and has a tantrum. Or parents of a four-year-old may worry about occasionally wet pants. Such behavior is normal for children of these ages. In such cases much of the parents' worry may disappear if you give them information about how other children this age usually act, or if they can visit the center or day home to observe the other children. You need to help these parents learn to worry less, or it may cause the child to worry.

7. Depression. After parents have begun to accept the fact that their child will be different and that the diagnosis is correct, they frequently become very depressed. They may feel that it is pointless for the child to learn to play with other children, or to learn to do the things other children of that age normally do. Sometimes parents begin to withdraw from their child. They may appear to reject the child or treat the child as if they were not the parents. While this is one way for parents to deal with their feelings, it can be damaging to the child. The child still needs to feel the emotional care and love of adults.

As a caregiver you cannot change the parents' feelings of depression or withdrawal from their child. However, you can give the child the additional emotional support and love that is needed. Again, do not evaluate or judge others, but do all you can yourself.

8. Accepting the situation. Almost always, when discussing children who are handicapped, someone suggests that parents should "accept" their child and the problem. But what does it mean to be an accepting parent? How can teachers help parents feel this way?

Accepting children, handicapped and nonhandicapped, means knowing what they **can** do and being proud of their accomplishments. It also means being aware of what they cannot do and giving them the help they need. It means giving children work to do which makes them feel independent, but not so much work that they are frightened or defeated. It means helping them when they need it, but letting them try to work by themselves so they can learn from mistakes. It means giving them the love and support all children need, but not trying to shelter them from all the little hurts all children experience. Most of all, it means loving children and showing this love in ways that do not overprotect them and being ready to help them do their best in spite of any problems.

If this sounds like a great deal to expect, it is. Sometimes it takes parents many years to be able to feel this way. Even the parent or teacher who is very accepting will still feel discouraged, angry, or hopeless at times.

As the child's teacher/caregiver you can be of great assistance to parents in working with their handicapped child. Any time you talk with parents, try to tell them about all the things their child can do. Show them your willingness to accept and work with their child. If the child has trouble with some things, show them ways he or she can be helped to learn. Suggest things to do at home with the child. Each parent needs a different amount of information or support from you.

Reactions of Parents

1. Refusing to believe there is a problem.
2. Feeling angry.
3. Wanting to blame someone.
4. Feeling guilty.
5. Looking for a cure.
6. Worry and fear for the future.
7. Depression.
8. Accepting the situation.

NORTHWEST CENTER
CHILD DEVELOPMENT PROGRAM

Dear Parents: August 28, 1984

Congratulations and thank you! Our goal was to receive all the "strengths and needs" assessments from you by August 30, 1984. We have almost 100%. For your information the results are as follows:

The majority of your returns indicated you would like topics presented at parent meetings in this order frequency of requests:

1.	Child Development	32 responses of critical
2.	Health Issues	24 responses of critical
3.	Education	18 responses of critical
4.	Family Interactions	14 responses of critical
5.	Support Systems	13 responses of critical

In response to your interests, the evening parent programs will cover these topics. Plan ahead for a year of good information!

EVENING PARENT MEETING SCHEDULE
1984-1985

- 3rd Monday of month
- 6:00 potluck dinner
- 6:30 program
- 7:30-8:00 visiting/discusion time
- Bring friends and ideas

* Child care available for $1 per family

SEPTEMBER 17 Orientation night for families	OCTOBER 22 "Child Development Overview" to include: Communication development Physical development	NOVEMBER 19 Health Issues to include: Nutrition Topics of choice	DECEMBER No Meeting ENJOY HANNUKAH AND CHRISTMAS!
JANUARY Educational theories and practices	FEBRUARY Family Dynamics and interactions	MARCH "Preventing Parent Burnout"	APRIL Transition Workshop for families of children with special needs
MAY "Talking about touching with children"	JUNE Gala Family Picnic	FAMILY SERVICES Liz Mercer Leslie Keller	

Sincerely,

Linda Gil

Linda Gil
Program Director

Resource #2C, Evening Parents Meeting Schedule.

VALUES TO INSTILL IN YOUNG CHILDREN

DIRECTIONS: Please read this list of values. Place a star (*) by the 5 values you feel are most important to instill in young children. Be prepared to discuss ways in which your choices can be taught in the child care center.

___AMBITIOUS (hard-working, aspiring)	___INDEPENDENT (self-reliant, self-sufficient)
___BROADMINDED (open-minded)	___INTELLECTUAL (intelligent, reflective)
___CAPABLE (competent, effective)	___LOGICAL (consistent, rational)
___CLEAN (neat, tidy)	___LOVING (affectionate, tender)
___COURAGEOUS (standing up for your beliefs)	___LOYAL (faithful to one's friends, group)
___FORGIVING (willing to pardon others)	___OBEDIENT (dutiful, respectful)
___HELPFUL (working for the welfare of others)	___POLITE (courteous, well-mannered)
___HONEST (sincere, truthful)	___RESPONSIBLE (dependable, reliable)
___IMAGINATIVE (daring, creative)	___SELF-CONTROLLED (restrained, self-disciplined)

Resource #3A

List from Values Survey by Milton Rokeach, Halgren Tests.

CRITERIA TO CONSIDER BEFORE DESIGNING AN ENVIRONMENT

QUESTIONS:

Who is my learner population?

Where are the characteristics of that population?

What do I want them to learn?

How do I want to learn?

What materials do I have to accomplish this?

What materials do I need?

How can I accomplish what I want if I can't have all the equipment I think I need?

What is my role in the environment?

Resource #3B

Criteria to Consider Before Designing an Environment.

From Northwest Center Child Development Program,
by K. S. Wend and L. Gil.

ARRANGEMENT OF MATERIALS

The best information to follow regarding arrangement of materials centers around two important considerations.

First, materials need to be available to children if they are to learn how to use them. That means materials must be available to children at all times, and not just when the teacher thinks they should be available. Children simply will not explore, combine and create with materials if they do not have access to them.

Second, materials must be displayed in a way that children, no matter what their level of development, might be attracted to them.

Let's talk about availability first.

AVAILABILITY OF MATERIALS FOR CHILDREN: BIRTH - THREE YEARS

Usually, no matter what the model of your program, it is appropriate to have materials available for children to explore. That doesn't mean you have to have all the materials available all of the time, but a sufficient number to retain the interest of the children. They must always be in good repair. That is a must. They must always be clean.

In Northwest Center's program, the classrooms have cross-age groupings. That means that whether having a handicapping condition or being normally developing, children in some classrooms range between the ages of four months and three years. In that range, children are approximately at the infant stage, toddler stage, or early preschool stage of development.

Infants need toys that are safe to mouth, manipulate, and bang. The toys need to be colorful, non-breakable and durable. Those toys need to be at a level where an infant can reach for, crawl to, or grab for them, and experience success.

Toddlers need toys that allow them to put in and take out items, stack items, push/pull items, and bang objects for the purpose of experimenting with their sounds.

Resource #3C

Arrangement of Materials. From Northwest Center Child Development Program, by K. S. Wend and L. Gil.

AVAILABILITY OF MATERIALS FOR CHILDREN: BIRTH - THREE YEARS
(continued)

Preschoolers need toys and items that allow for early stages of imaginative play, increased fine motor experiences (pegs, puzzles, and things with tinier pieces), and toys that promote more language and communication experiences.

All children under three years of age need sensory experiences (feel, taste, touch, smell, see). All children under three years of age need music, to be read to, to be talked to, to be listened to, and they need to have times that are quiet and times that are loud. This applies to children in all-day programs, half-day programs, and any other arrangement. The length of any of the experiences varies, depending on the type of the program and the length of the daily program.

Let's talk about Arrangement of Materials.

ARRANGEMENT

A simple rule to follow is to have the materials that include the least amount of pieces and that require the least amount of adult assistance to be on the level most accessible to children. Gradually, the materials of increasing difficulty and numbers of pieces are displayed on higher shelves. Scissors, puzzles with many pieces, and beads, etc., are on on shelves that may require teacher assistance to retrieve. These materials are visible to the child and displayed in a way that encourages the child to choose them.

For example, in Northwest Center's program, in the cross-age groups of children ages four months to three years, all infant toys are on the low shelves where the infant can crawl to and get the toys independently, or they are in a safely designed area called an infant area.

The toddlers' toys are on the next shelves up, where only a child now in a more upright position, and probably cognitively ready to manipulate more complicated materials, will be able to reach.

Finally, the highest shelves hold the materials reachable by a preschooler, who is probably able to manipulate more complicated materials.

ARRANGEMENT

(continued)

What does this mean for a child who might have a physical handicapping condition, be in a wheel chair and yet cognitively be at a "preschool age level"? It means that the child can visually observe the materials and communicate her desire to use them, at which point the teacher brings them to her level.

Materials need to be arranged in a manner that convey the use of the item. For example, in the manipulative area, items need to be in containers that are clearly marked with a picture of the item and spaced at least five inches apart on shelves. Children cannot visually discriminate items that are stacked on top of one another or mixed up with other items.

In the dramatic play area, hats, dress-up items, dishes, etc. need to be displayed clearly. Children do not know what to do with a box of clothes, or a box of dishes, until they are nearer elementary age. Even in the infant area, toys need to be clearly displayed and arranged so that children can work to explore, manipulate, combine and expand upon them. This means putting infant toys on a low shelf with each toy about five inches apart, rather than in a laundry basket or other container through which a child would have to search in order to choose a toy.

For children who are developing at their chronological age level in the area of physical development, but not socially or cognitively age appropriate, expect them to use the materials at their cognitive level, whatever that may be.

MAKING THE FACILITY ACCESSIBLE

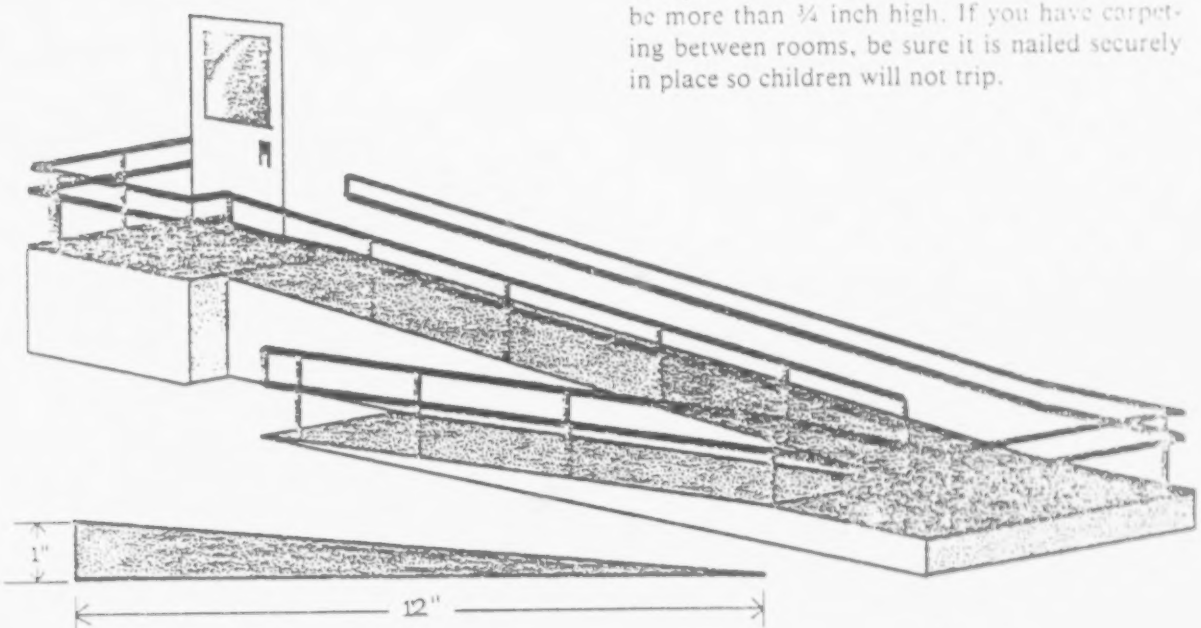
Both handicapped children and adults must be able to enter the center or day home and move around with ease. You may need to adapt or modify your facility for accessibility.

There are some general considerations and adaptations to your facility you can make which will be of help in preventing accidents for handicapped children. These modifications will help make it easier for handicapped children or handicapped adults to enter or leave the building and the classrooms. These modifications do not involve moving walls or permanent fixtures. They can usually be made at minimum cost.

1. Entrance ramps. If the building is not at ground level, entrance ramps are needed for children who are in wheelchairs, use crutches or leg braces or have motor problems, as well as for visually-impaired children. Ramps should be 36 inches wide and have a very gentle or slight slope. An inexpensive ramp can be made from heavy plywood.

2. Door openings. For children who are in wheelchairs, door openings should be at least 32 inches wide.

3. Door thresholds. For children with motor problems or visual handicaps, door thresholds can present problems. Thresholds should not be more than ¾ inch high. If you have carpeting between rooms, be sure it is nailed securely in place so children will not trip.



The ramps should not rise more than 1 inch in height for every Foot of horizontal distance.

Resource #4A, Making the Facility Accessible.
From When You Care For Handicapped Children.

4. Floors. Floor and stair coverings should be of non-slip material. If you have tile floor coverings in rooms or hallways, they should not be heavily waxed and slippery.

5. Stairs. If there are stairs which children must climb, they should be enclosed and should not have an extended edge over which a child might trip.

In some cases, there will be structural modifications that need to be made to make a building or room accessible to handicapped children. These might involve moving a wall or adapting permanent fixtures. **If you plan structural changes to your facility, you must consider local and state building requirements.** These requirements will provide information on structural adaptations for the handicapped. They will also address other areas that will make your facility accessible to and usable by handicapped children or handicapped parents.

RECOMMENDED

THESE VERTICLE OR SLANTED, AND SLANTED UNDERSIDE STAIRS HAVE NO EDGES A CHILD WEARING LEG BRACES CAN TRIP ON

NOT RECOMMENDED

THESE STAIRWAY DESIGNS HAVE PROTRUDING EDGES THAT MIGHT TRIP CHILDREN WEARING LEG BRACES

EARLY INTERVENTION IS IMPORTANT

Research has shown that the years from birth to school age are the most critical for growth and development of all children, and that while most children grow in an orderly and predictable way, children with developmental special needs require comprehensive services if they are to overcome the negative effects of developmental delays.

Persuasive arguments in favor of early educational opportunities were made by researchers who concluded that experiential influence is greatest during the first few years of life. A summary of the reasons for early intervention for the child who is handicapped or who is shown to be at high risk for developmental disabilities includes:

- Early experience does have an influence, and that influence affects all areas of functioning.
- Research has shown that there may be critical periods for the development of certain skills, and that most of these periods may occur during the first three years of life.
- Failure to provide a stimulating early environment leads not only to a continuation of the developmental status quo, but to actual atrophy of sensory abilities and to developmental regression.
- Early intervention has been shown to help: it can work to reduce the effects of a handicapping condition, and can do so more surely and rapidly than later intervention.
- Parents need support during early weeks and months, before patterns of parenting become established; parents need models of good parenting behavior with a handicapped child, and specific instructions for working with the child.

Resource #4B

Early Intervention Is Important. From the Washington Preschool Planning Board.

EARLY INTERVENTION IS COST EFFECTIVE

The cost of providing special education programs was calculated recently. When intervention began during the child's first two years, the cumulative cost to age 18, with some children graduating into regular education programs, amounted to $37,000 per child; if intervention was delayed until age 6, with no movement into regular education, the total cost rose to over $53,000. Thus, early educational intervention can save as much as $16,000 per child. Additional benefits such as encouragement and support to families for maintaining the special needs child at home have not yet been documented in dollars.

* * * * * *

This information was compiled by the PRESCHOOL PLANNING BOARD from data supplied by The Association for the Severely Handicapped (TASH) and the Council for Exceptional Children (CEC). The Preschool Planning Board, a project of the Washington State Developmental Disabilities Planning Council, funded by P.L. 95-602, seeks to expand the availability of preschool programs throughout the state of Washington for young handicapped or high risk children ages birth to five years.

For additional information please contact:

Preschool Planning Board
Laila Hammond, Public Awareness Coordinator
P. O. Box 2331
Olympia, WA 98507 (206) 357-5596

I M P A C T

For Developmental Education, Inc.

INTAKE REPORT

NAME: L.G.
D.O.B.: 7/4/84
C.A.: 19.1 months
BY: J.M.S.

DATE: 2/6/86
REFERRED BY: Dr. K.D
SCREENING INSTRUMENT:
Carolina Curriculum
for Handicapped Infants

REASON FOR REFERRAL

L. is a 19.1 month old girl referred to IMPACT by Dr. K. D. due to her small head circumference and his concerns about her gross motor development. At birth there was a "club foot deformity" which has been repaired. A heel-cord lengthening procedure was done at 9 months of age. She has been evaluated by Dr. B., a neurologist at Philadelphia Children's Hospital. Her growth and head circumference continue to be monitored. She has no firm diagnosis at this time.

GENERAL OBSERVATIONS

L. was seen by IMPACT on several occasions. Except for a session when she exhibited tired and unresponsive behavior due to an ear infection, L. is a small, animated little girl. She was initially shy with strangers but soon warmed to, and interacted with, all adults. She participated in a wide range of activities, demonstrating functional use of objects and age appropriate fine motor and bilateral hand skills. L. received a physical therapy evaluation at the Center. (See attached report.) Both Mr. and Mrs. G. attended.

CCHI RESULTS

Cognition	18 months	Communication	12 months
Social	18 months	Self-Help/Adapt.	18 months
Fine Motor	15 - 18 months	Gross Motor	12 months

Resource #4C

Sample Intake Report

I M P A C T

For Developmental Education, Inc.

INTAKE REPORT (Continued)

BEHAVIORAL SUMMARY

L. appears to be an active and very social girl. She interacts well with adults and children at her child care center. Her adaptive/self-care skills are at age level. Her parents report that she likes to attempt tasks such as teeth brushing independently. L.'s relative areas of weaknesses are in gross motor and vocal communication skills. L. cruises furniture but cannot yet walk independently. She demonstrates solid receptive communication skills such as pointing to known objects and people on request and can make some of her needs known (i.e., indicating down or "get it"). She also demonstrates good gestural imitation skills. L. needs to strengthen her vocal imitation and expressive language skills. Her fine motor skills were age appropriate.

Mr. and Mrs. G. are active and involved parents. They expressed their concerns regarding L. and were receptive to recommendations.

RECOMMENDATIONS

Because of L.'s gross motor and expressive language delays, collaborated by her pediatrician's "high risk" statement, eligibility for services is recommended. The least restrictive, optimum placement for L. would be in IMPACT's homebased program with regularly scheduled physical therapy sessions, as well as therapeutic visits to her child care center to demonstrate appropriate activities and exchanges. A speech and language evaluation is also recommended. Counseling and parent training should be made available to Mr. and Mrs. G. to assist them in setting appropriate expectations for L. The G.'s were encouraged to participate in the IMPACT Parent Support Group.

RECOMMENDED TARGET BEHAVIORS

Barrier: G. Motor Skills

Beh: L. will increase her lower body strength and balance by participating in activities designed to promote independent walking. (10 min.)

Barrier: Weak Vocal Imitation and Expressive Language Skills

Beh: L. will participate in a variety of activities that will demonstrate consistent vocal imitation skills (5 min.)

I M P A C T

For Developmental Education, Inc.

INTAKE REPORT (Continued)

RECOMMENDED TARGET BEHAVIORS (Continued)

Beh: L. will increase her expressive vocabulary by using action and agent/object words.

Barrier: On Task Behavior for Fine Motor Tasks

Beh: L. will remain on task for 5 min. while manipulating a variety of fine motor materials (e.g., crayons, blocks, shapebox).

EVALUATION/GOALS

Name: G., L. SS# None Date 02/20/86

SECTION A

PSYCHOLOGICAL EVALUATION

L. was assessed with the Carolina Curriculum for Handicapped Infants on 2/6/86, by J.M.S. She was found to be experiencing delays in gross motor and communication skills. The results of testing indicate L. is functioning at these developmental levels:

Cognition	18 months
Social	18 months
Fine Motor	15-18 months
Communication	12 months
Self-Help/Adapt.	18 months
Gross Motor	12 months

PSYCHOSOCIAL

Date: 2/20/86
Evaluator: R. F.
Instrument: Social Service Intake

L. is a one-year old female who resides with her parents. L. does not yet have a Social Security number.

Mr. and Mrs. G. are active and involved parents. They express concerns regarding their daughter and are requesting guidance in regard to her specific needs.

Recommendation: L. should receive a Social Security number. L.'s parents should be involved in a parent training program to provide support and guidance in regard to their daughter's needs.

MEDICAL

Date: 2/17/86
Evaluator: A.J.S., SCHN
Instrument: Review of records

We have a High Risk Statement by K. D., M.D., stating Microcephaly, or small head circumference, dated 1/16/86. L. was born with a club foot, which has been corrected by casting. At nine months of age she had a right heel cord lengthening. On 2/25/86, through one day surgery, L. had a subcutaneous tenotomy of the right Achilles tendon with the application of a fiberglass long leg cast. Blood work done

MEDICAL (Continued)

at that time was all within normal limits. On July 30, 1985, she visited Dr. P. H. B., M.D., a neurologist of Philadelphia. His impression at that time was borderline microcephalic and some spasticity in the right lower limb - probably related to prenatal events. An EEG done at that time was within normal limits. L. has hazel eyes and brown hair. She is approximately 20 lbs.

S A M P L E IEP

NAME L. G.

IMPLEMENTATION DATE 3/86

SKILL AREA Fine Motor

PROJECTED COMPLETION DATE 3/87

DEVELOPMENTAL AGE LEVEL 15 - 18 months

ASSESSMENT Carolina Curriculum for Handicapped Infants

ANNUAL GOAL	SHORT TERM OBJECTIVES	MATERIALS	QUARTERLY REVIEWS	COMPLETION DATE
L.G. will remain on task for 5 min. while manipulating a variety of fine motor materials (crayons, blocks, shape box).	1. L.G. will stack: a. Blocks of cans b. 4 blocks c. 6 blocks	cans blocks		
	2. L.G. will complete a pegboard with small pegs: a. with assistance b. with touch cue c. on verbal cue	pegs pegboard		
	3. L.G. will complete a 3 piece formboard a. circle b. circle & square c. circle, square, & triangle	3 piece formboard circle formboard square formboard triangle formboard		
	4. L.G. will initate drawing a vertical stroke: a. with assistance b. complete last half of stroke independently c. independently	crayons paper		

S A M P L E IEP (Continued)

NAME L. G. IMPLEMENTATION DATE 3/86

SKILL AREA Fine Motor PROJECTED COMPLETION DATE 3/87

DEVELOPMENTAL AGE LEVEL 15 - 18 months ASSESSMENT Carolina Curriculum for Handicapped Infants

ANNUAL GOAL	SHORT TERM OBJECTIVES	MATERIALS	QUARTERLY REVIEWS	COMPLETION DATE
L.G. will remain on task for 5 min. while manipulating a variety of fine motor materials (crayons, blocks, shape box).	5. L.G. will initiate: a horizontal stroke a. with assistance b. complete last half independently c. independently			
	6. L.G. will complete a 3 piece shape sorter a. circle b. circle & square c. circle, square, & triangle	3 piece shape sorter		

THE IEP - WHAT IT IS

The IEP (Individual Educational Program) is a written plan for an exceptional child's special education. It describes the child and what the parent and the school will do to give him the extra help and attention he needs.

The IEP is a little like a roadmap for a child's special education. It describes what a child can already do and what he needs to learn. It lists the kinds of special help that a child will need to have in order to learn. The IEP will have in it everything that the parent and the school agree is important for a child's education. The IEP will tell you:

What programs and services a child should get.
What kinds of things a child can do and what he needs to learn.
What a child should have learned at the end of a year.
How much time he will spend in exceptional, regular and/or vocational education.
Things parents have agreed to do to help their child.
Dates when the IEP will begin, end, and be reviewed.
How a child's progress will be measured.

NOTE: There are two very important things to remember about IEP's:

THE IEP IS WRITTEN FOR EACH EXCEPTIONAL CHILD

THERE IS ONLY ONE IEP AT A TIME FOR A CHILD

THE IEP - WHAT IT IS NOT

The IEP is NOT a daily lesson plan. the IEP covers a whole year. It will not tell you each little thing that a teacher will do with a child. It won't take the place of the kinds of plans that teachers write for a day or week.

The IEP is NOT an evaluation report. An evaluation report describes a child's strengths and weaknesses. It lists his interests and special learning needs. The information from an evaluation report is used to help write the IEP.

Resource #4F

The IEP: What It Is. From Training Manual for Exceptional Student Aides. Produced by The Florida Diagnostic Learning Resources Center.

THE IEP - WHAT IT IS NOT (Continued)

The IEP is NOT a contract. The IEP describes things that parents and the school have agreed to do for a child. It cannot promise that all the special help will work. There are many things that affect a child's learning. The school cannot control a child's health, or things that happen outside the school, for example.

The IEP does NOT last forever. As a child grows, learns, and changes, the IEP will need to change. It must be reviewed at least once a year. It may be changed as often as parents and the school agree that it needs to be changed.

SPECIALISTS FOR SPECIAL NEEDS

An **Audiologist** conducts screening and diagnosis of hearing problems, and many prescribe a hearing aid or suggest training approaches for people with hearing handicaps.

A **Dentist** conducts screening, diagnosis, and treatment of the teeth and gums.

A **Nutritionist** evaluates a person's food habits and nutritional status. This specialist can provide advice about normal and therapeutic nutrition, and information about special feeding equipment and techniques to increase a person's self-feeding skills.

An **Occupational Therapist** plans and directs activities for promoting self-sufficiency in a handicapped child. Particular attention is paid to improving fine motor skills, such as those involved in eating and dressing.

An **Opthalmologist** is a medical doctor who conducts screening, diagnosis, and treatment of diseases, injury, or birth defects that limit vision.

An **Optician** assembles corrective lenses and frames. He or she will advise in the selection of frames and fit the lenses prescribed by the optometrist or ophthalmologist to the frames. An optician also fits contact lenses.

An **Optometrist** examines the eyes and related structures to determine the presence of visual problems and/or eye disease, and to evaluate a child's visual development.

An **Orthopedist** is a medical doctor who conducts screening, diagnosis, and treatment of diseases and injuries to muscles, joints, and bones.

An **Otolaryngologist** is a medical doctor who conducts screening, diagnosis, and treatment of ear, nose, and throat disorders.

Resource #4G

Specialists for Special Needs from Headstart Mainstreaming Preschoolers Series

SPECIALISTS FOR SPECIAL NEEDS

(Continued)

A **Physical Therapist** evaluates and plans physical therapy programs and directs activities for promoting self-sufficiency primarily related to gross motor skills such as walking, sitting, and shifting position. He or she also helps people with special equipment used for moving, such as wheelchairs, braces, and crutches.

A **Psychiatrist** conducts diagnosis, and treatment of psychological, emotional, behavioral, and developmental or organic problems. Psychiatrists can prescribe medication. They generally do not administer tests. There are different kinds of psychiatrists.

A **Psychologist** conducts screening, diagnosis, and treatment of people with social, emotional, psychological, behavioral, or developmental problems. There are many different kinds of psychologists.

A **Social Worker** provides services for individuals and families experiencing a variety of emotional or social problems. This may include direct counseling of an individual, family, or group; advocacy; and consultation with preschool programs, schools, clinics, or social agencies.

A **Speech-Language Pathologist** conducts screening, diagnosis, and treatment of speech and language problems. This specialist may also be called a **speech clinician** or **speech therapist.**

LIFTING, CARRYING, AND TRANSFERRING

When techniques of lifting, carrying, and transferring children are correctly executed, stress and possible injury to the child and adult are avoided.

1. Never attempt to lift, carry, or transfer a child who is too heavy or too difficult to manage alone. If two (2) people cannot manage the procedure, a mechanical lifter may be required. This should be carefully selected and operated only by a person familiar with its use.

2. Prior to lifting, the specific movements should be planned. If another person is assisting they should discuss the procedures to coordinate their movements.

3. The chair, bed or other surface should be properly positioned to facilitate the procedure. If a wheelchair is involved, the brakes must be applied and the footrests must be lifted or removed.

4. Quick movements of the child must be avoided. This may cause fear in the child and spastic muscles will become more tense.

5. The child should be told what is to occur and how he can assist in the process.

6. Proper body mechanics should be followed, e.g., bend at the knees, not at the waist, get as close to the child as possible; keep the back straight; avoid lifting higher than the waist; do not lift quickly.

Principles of Good Lifting

1. First, plan the job.

2. Be sure that there is ample room for good footing and that the path is cleared for the carry or transfer.

3. Stand so you will not have to twist your body as you lift the handicapped child.

Resource #5A

"Lifting, Carrying, and Transferring." From Training Manual for Exceptional Student Aides, Produced by the Florida Diagnostic Learning Resources Center.

LIFTING, CARRYING, AND TRANSFERRING
(Continued)

Falling While Carrying

1. If close to a wall or other stable object, rest weight on it.

2. Be alert to protect the child's head.

3. Fall under or to the side of the child.

4. Turn child away from hard objects.

5. Fall against the bed or other soft object, if close.

6. If falling downstairs, try to lower to sitting position on step.

7. If falling upstairs, turn and sit on the stairs, holding onto the child.

8. After stumbling, crouch and sit down to prevent tumbling.

Lifting Heavy Child without Braces from Floor to Standing Position

1. Kneel close behind the child and grasp him under his armpits, with the grasp pressure against the trunk.

2. Raise the child to a sitting position.

3. Shift to a stride position with your knees bent and back straight.

4. Still grasping the child under the armpits, raise him to a standing position by straightening your legs and shifting your weight quickly toward your rear foot.

Assisting Child to Walk During Change of Position

If the child is able to support his weight on his legs and is able to take steps but has difficulty in maintaining his balance, assist him/her as follows:

1. Stand close behind him/her so that your forward leg is in contact with the child.

2. Grasp his waist or the waistband of his brace with one hand. Place your other hand over his shoulder or under his armpit.

LIFTING, CARRYING, AND TRANSFERRING
(Continued)

3. As the child moves forward, keep your hand or leg in contact with him.

4. Use your leg to assist the child in moving forward by swinging the leg forward against his buttock in a lifting motion.

Assisting the Child Who has Lost His Balance

If the child starts to fall while walking, step close to him and place your leg next to him/her for support or to break his fall.

If the child is falling toward you, crouch and place one leg under him or place your thigh against him while supporting his upper trunk with your hands.

> **CAUTION:** The goal should be to prevent injury, not to regain balance. Do not reach outward or lean over to catch him.

Assisting Child to Walk Downstairs

1. At the top of the stairs, place the child's hand or both hands on the rail, and while steadying him, move to the step below him and face him.

2. Grasp the child's waist and move to the next lower step. Stay close to the railing. Keep your weight forward. Rest your arm and hip against the rail.

Carrying a Child Horizontally, if Necessary

1. Hold the child with one of your arms under his knees and the other under his chest, your palms facing upward.

2. Hold the child tightly against your body to relieve arm strain and prevent shifting.

3. Take short steps to maintain balance; do not walk fast.

4. Keep your hips under the load of your upper body and the child.

5. Walk with a large share of the weight over your heels.

6. To carry a heavy child for short distances, support his weight against your upper thighs. Keep your hips slightly flexed.

Type of Transfers

A transfer is the process of moving from one place to another. As discussed here, it refers to moving a person from a bed to a chair, from a wheelchair to an automobile, from a wheelchair to toilet, etc.

Transfers may be from a horizontal or a vertical position. Horizontal transfers are necessary if the child is totally dependent and is confined to a recumbent position. This applies to a child with total paralysis, a body cast, or spinal injury. In the majority of instances, this type of transfer requires the assistance of other persons and is usually performed in a hospital or at home if the child is confined to bed.

Vertical transfers are accomplished with the head and trunk erect as a person transfers from one seat to another. Various methods for vertical transfers are discussed on the following pages.

1. **Weight-Bearing Transfers**

   a. Independent weight-bearing transfers may be performed by the child with at least one strong leg for support and good trunk control.

2. **Non-Weight-Bearing Transfers**

   a. **A depression transfer** is generally considered the most useful method of a non-weight-bearing transfer. The child pushes down with his hands on the seat or armrests to lift himself. Then he slides to the adjacent surface which should be of equal or slightly lower height. A smooth board of about 6" x 20" called a sliding board may be necessary to bridge the gap between the surfaces.

   b. **An overhead or chinning transfer** is performed by the child pulling up on a trapeze or other overhead support to lift the body weight. A sliding board may be necessary. This would usually be performed at home or at a hospital where the trapeze is permanently installed overhead.

LIFTING, CARRYING, AND TRANSFERRING
(Continued)

Lifting Child from Wheelchair to Standing Position

1. Apply wheelchair brakes. Face the child.

2. Crouch to swing footrests into vertical position, out of the way of the child's feet.

3. Stand in a bent knee position with forward leg between the child's knees and place your hands about the child's chest or under his armpits.

4. Shift your weight backward over the rear foot as you slide the child to the front of the seat.

5. Have the child lean forward and keep his weight over his feet as you draw him up to a standing position. It may help if he holds your hips or shoulders.

CARRYING

Principles of Good Carrying

1. Avoid carrying whenever possible by using a household chair with wheels added, tricycles, wheelchairs, or hydraulic lifts.

2. When carrying is absolutely necessary, hold the load as close to your chest as possible.

3. Keep a firm grasp. If your grasp becomes loose, rest the child against something while you secure a firmer grasp.

4. Do not twist; turn your whole body.

LIFTING, CARRYING, AND TRANSFERRING
(Continued)

Carrying a Child without Unnecessary Strength

1. Keep your arms close to your body.

2. Rest part of the child's weight on your hips and counterbalance his weight by leaning back from slightly flexed knees, without hypertension of the lumbar spine.

3. Have the child lean against you, since he cannot help by holding your shoulders.

4. Stand close to the load with one foot ahead of the other; the foot that is ahead should usually be in the direction you are going.

5. Do not try to lift from a kneeling position, as this takes away the power source. However, with smaller children or loads, it may be advantageous to start to lift with one knee on the floor.

6. Get a good grasp before starting to lift.

7. Make a preliminary lift to see if the student weight is within your capacity.

8. If the weight of the load is more than one-fourth of your body weight or if it is awkward, you should get someone to help you.

9. Lift one end of the load slightly, if necessary, so you can place one hand underneath it in order to get a firm grasp.

10. Get your legs ready for the lift by bending them. Do not attempt to lift a load with your legs bent beyond the right-angle position.

11. Lower your body near the level of the object to be lifted.

12. Be sure your back is straight. If it is neither rounded nor arched, and is as near the vertical position as possible, you will avoid strain.

13. Be sure your shoulders are directly over your knees and your hands reach straight downward to the load.

14. To be in the proper position, let your back muscles hold your back steady as your leg muscles tense to go to work.

15. Lift by straightening your legs in a steady upward thrust, and at the same time move your back to a vertical position.

LIFTING, CARRYING, AND TRANSFERRING
(Continued)

Carrying a Child without Unnecessary Strength (Continued)

16. Keep the weight of the load close to your body and over your feet.

17. As your legs straighten, keep your back straight.

18. To change direction during a lift, step around and turn your whole body, without twisting at the waist or lower back.

Procedures for Independent Weight-Bearing Transfers

1. The child positions his wheelchair at an angle of 90 degrees or less to the surface where he is moving. If one leg is stronger, this side is placed toward the surface where he is moving.

2. The child applies the wheelchair brakes and raises or removes the footrests. Swing-away or removable footrests are ideal for allowing space for maneuvering. Removable armrests on a wheelchair allow the child to transfer without standing.

3. The child moves forward to the edge of the chair and places the strongest leg directly under the edge of the chair and the weaker leg forward slightly for balance.

4. The child leans forward on the strong foot and extends his legs to stand while simultaneously pushing down with his hands on the seat or armrests to lift himself.

5. He reaches for the surface where he is moving and pivots on his strong foot until his back is toward the surface. When he feels the surface behind his leg, he sits.

    a. Dependent weight-bearing transfers may be performed with the assistance of one person when the proper procedures are followed.

Procedures for Dependent Weight-Bearing Transfers

1. Follow steps 1, 2, 3 listed under Procedures for Independent Weight-Bearing Transfers.

2. The person assisting stands in front of the child with his feet slightly apart and knees bent. The legs are in a position to block

Procedures for Dependent Weight-Bearing Transfers (Continued)

the child's knees if they give way. The bent knees also reduce the stress on the back and allow for maximal lifting strength.

3. The person assisting holds the child under the arms. A towel placed under the child's arms may offer a more secure grasping surface.

4. The child leans forward over the strong foot and extends his leg to stand. The person assisting shifts his weight backward and assists the child to a standing position.

5. As the child comes to a standing position, he reaches for the surface where he's moving and pivots on his strong foot until his back is toward the surface. As the person assisting shifts his weight forward, the child is slowly lowered to a sitting position.

ASSISTING WITH FEEDING, DRESSING, AND EXERCISING

Assisting the Handicapped Child When Feeding

Many children with multiple handicaps have difficulty in chewing, sucking, and swallowing in addition to difficulty in using utensils for self-feeding. Poor functioning of oral muscles also may cause continual drooling and speech impairments.

Developing feeding skills is important for the child's nutrition and for his learning to care for himself. During the school day, the teacher can assist in promoting these skills during the periods for lunch and snacks. Specific techniques can be instructed by the speech therapist and occupational therapist. Suggestions from the parents who are the most experienced in feeding their child will be helpful.

General Guidelines for Feeding the Handicapped Child

1. The child should be placed in an optimal position for feeding. The speech or occupational therapist can demonstrate specific procedures for individual children. For example, neck and side supports will aid the child with poor head control.

2. Place food alternately at each corner of the child's mouth to encourage chewing.

3. To encourage use of the lips, have the child take the food off the spoon by closing his lips. Do not use his teeth to scrape the food off the spoon.

4. Small amounts of food should be in each spoonful for easier chewing and swallowing.

5. Begin with strained baby foods and gradually progress to foods which have been placed in the blender as the child becomes able to chew.

6. If able, have the child bite off a piece of toast or cracker rather than placing a piece in his mouth.

Resource #5B

Assisting the Child in the Classroom. From Training Manual for Exceptional Student Aides. Produced by the Florida Diagnostic Learning Resources System.

ASSISTING WITH FEEDING, DRESSING, AND EXERCISING (Continued)

General Guidelines for Feeding the Handicapped Child (Continued)

7. Distractions should be kept at a minimum when feeding the child or when teaching him self-feeding skills.

8. Adapted feeding utensils may be necessary for individual children to avoid unnecessary frustration and teach independence.

9. A rubber mat under a child's plate may be necessary to prevent movement of the plate as the child learns to scoop food off the plate.

10. In order to assist the child when self-feeding, the adult can sit behind the child to guide the utensil in the child's hand to his mouth.

Assisting the Handicapped Child When Dressing

The child's independence includes his ability to dress and undress himself. Although teaching dressing skills may not be a primary objective of the classroom, the teacher can allow the child every opportunity to learn these skills when taking his jacket off in the morning, undressing for toileting, removing his shoes for a nap, etc. The parents can serve as an excellent resource for the child's ability and the methods of dressing followed at home.

General Guidelines for Assisting the Handicapped Child When Dressing

1. Break the skill down into small steps and begin with the easiest. For example, the child first may learn to locate the front of the jacket before having to put it on.

2. Be aware of all the movements involved in dressing skills. Repeated practice of these movements leads to improvement.

3. Have the child practice removing a garment before trying to put it on. Removing clothes is usually easier than applying them.

4. In all dressing activities, the child should be encouraged to assist whenever he is capable. This may involve the simple task of raising an arm or a leg.

5. When practicing dressing, the garments used should be loose fitting with large openings for the head, arms, and legs.

Assisting the Handicapped Child When Dressing (Continued)

6. The child should be safely positioned when attempting new dressing skills. If he has poor balance, many dressing skills can be performed from a sitting or lying position.

7. If the child has difficulty in distinguishing the front and back of garments, a brightly colored iron-on or sew-on tape could be used.

8. If one leg or arm is weaker than the other, it is placed in the garment first. When undressing, the weaker arm or leg is removed last.

9. Usually fasteners are a more difficult skill to master and for this reason, they are often taught last. Often conventional fasteners need to be replaced with ones that are easier to manage.

10. Allow the child to succeed in small steps and give him praise for his accomplishments.

Assisting the Child When Exercising

If the child is participating in physical or occupational therapy, specific exercise may be recommended to be performed in the classroom as well as at home. These may be passive exercise, if the movements are performed for the child; or active exercise, if the child performs the movements by himself. Staff members may be requested to supervise his exercise practice sessions or if necessary, may be requested to perform passive exercises during the school day.

General Guidelines for Assisting the Handicapped Child When Exercising

1. Specific written instructions should be provided by the therapist for individual children.

2. It is recommended that parental permission is obtained when the aide performs passive exercises.

3. Passive exercises should be performed slowly without force. Fast movements cause increased muscle tightness and may lead to injury. Also if the child has been inactive for a long period, bones are easily fractured.

General Guidelines for Assisting the Handicapped Child When Exercising (Continued)

4. The adult should be aware of any signs of discomfort by the child such as grimacing or crying out. Passive exercise should not be painful.

5. Dislocated hips are common in children with severe spasticity, paralysis, and/or minimal mobility. The teacher must be aware of this and exact instructions must be provided by the therapist.

6. The child should be relaxed when passive exercise is performed. If he is frightened or crying, the muscles may become more tense or spastic.

7. When supervising a child performing active exercise, instructions should be clear and concise.

8. The child should be encouraged to count the repetitions, if possible, and to be responsible for performing the exercise correctly. Ultimately, the child is the person who will benefit from this activity and he should learn to be independent in performing it.

9. All exercises, active and passive, should be performed slowly so maximal benefit is attained.

10. Depending upon the age of the child, it may be necessary to make the practice session fun by playing games or singing songs. However, the main intent should be exercising and not play.

Activity Often Recommended by Physical Therapists

Range of Motion - the extent of movement within a given joint which is normally achieved through the action of muscles or groups of muscles. Passive ROM is a form of bodily movements carried out by an outside force (nurse or therapist) without the assistance or resistance of the patient. It involves gently moving body parts through all ways they can safely move, without exerting force.

Communication Systems

Major Systems of Communication

Since the earliest days of education of the hearing impaired in this country, there have been two major opposing philosophies concerning which system of communication is best to use with hearing impaired children. The two different philosophies can be categorized generally as:

- the oral approach
- the total communication approach.

Not only are these two philosophies opposed to one another, but within each philosophy there are a number of different systems of communication favored. For example, oral systems may differ from program to program. You may hear terms such as oral, aural-oral, auditory, auditory-global, or unisensory in reference to oral systems. For the purposes of this book, these systems will all fall under the general term **oral programs** though they differ in specific emphases and techniques. In total communication systems, you may hear reference to various sign language systems such as American Sign Language, Signed English, Seeing Essential English (SEE), Signing Exact English (See II), and so on. Although the specific sign system used may vary from program to program, the term **total communication approach** will be used here to encompass all of them.

As a teacher, you are not required to distinguish, learn, or use any of these special systems. But it may be useful for you to be aware of them. This section describes generally the two broad categories of systems, oral and total communication, so that you can know what is involved in each.

The basic goal of both methods is the same: to create an environment in which a child feels good about him- or herself and can learn to talk and to communicate with others to the best of his or her ability, so that the child may reach his or her full potential as a person. Both approaches emphasize the need to start training very early. And both utilize hearing aids and special training methods to teach listening, lip reading or speech reading, and speaking. Their basic difference lies in the fact that the total communication approach concentrates on teaching communication skills through the use of manual communication (a sign language system and finger spelling), listening, and watching, while the oral approach teaches these skills through listening and watching only.

In the total communication approach, manual communication is taught in addition to oral communication. In manual communication, **signs** and **finger spelling** are used in addition to speech, in order to communicate. Signs are hand movements that represent a word or concept. In finger spelling, single hand shapes representing letters of the alphabet are used to spell out words. For example, if a child wants to say "My name is Bobby," he may use signs for the words "my," "name," and "is." He may finger spell his name: B-O-B-B-Y. As he signs and spells the words, he may also say them, to the best of his ability. Speaking and signing English together is referred to as **simultaneous communication.**

Resource #6A, Communication Systems. From Headstart Mainstreaming Preschoolers series: Children with Hearing Impairment.

Our philosophy of mainstreaming children who sign is to have an interpreter-tutor become an integral part of the mainstream classroom. This person translates what the regular classroom teacher and students say into sign language. This person also helps the child who signs and the hearing children in the class by special tutoring. In this way the child who signs is given the needed support to enable him or her to keep up and understand what is going on in preschool. The classroom teacher and all the children in the class are given the opportunity to learn some sign language, if they are interested. Many children are eager to learn to sign; some are not. With some other children in the class knowing how to sign, it is felt in this philosophy that there is greater opportunity to develop meaningful social and educational integration.

In the oral approach, the emphasis is on helping hearing impaired children utilize their hearing to its highest potential, and on teaching them to use both listening and lip-reading skills to develop spoken language.

There is controversy among professionals in the field of teaching the hearing impaired as to which approach best achieves the basic goal. The specialists you talk to may have strong feelings about the subject. However, what is important for you as the Head Start teacher, and for the hearing impaired child in your class, is to know which approach the child's parents have chosen. For any system to work, it must be consistent. When a hearing impaired child enrolls in your class, you become a member of a team of people who are working on this child's communication skills. This team includes the parents and family, specialists in the hearing impairment program, you, and the children in your class. It is important that everyone who is involved with the child supports the method and techniques being used to teach the child.

This means that if the child is from a program using the oral approach, you will want to reinforce and encourage the child's listening and speaking skills. If the child is from a program using the total communication approach, you will want to do the same thing. But in addition, you will want to accept and be positive about the child's ability to use sign language, and about any other techniques using signs that may be recommended by the hearing specialist.

In either case you should ask the parents and/or the special education teacher how you can best support the teaching methods and system of communication being used.

The Oral Approach

The Total Communication Approach

WHAT SHOULD WE TALK ABOUT?

In order to talk with children, and to understand their needs, we need to share a common vocabulary. Children without communication disorders learn our vocabulary through observation, imitation, and maturational processes. Children with communication disorders may need to be taught a vocabulary, one unit at a time.

- Begin by making a list of ways the child communicates at home and at school with parents's help.

- Go through the list provided, and ask parents:

  "Mr. Jones, how does Janet tell you what she needs? When she wants more juice?", etc.

- Make sure that new words or signs taught at school are also taught at home.

TALKING TOPICS

Be sure you can communicate to the child about:

- Food consumption, food items, lunch, snack
* - "More"
- Movement, location - come here, on, under, in
- Beginning, ending - start/stop
- Toileting - wet, dry, potty
* - Praise and "no" - good job, bad job
* - Names of simple toys - ball, block
* - Help me
- Open and close
- Hurt, or "it hurts"
* - Greeting - hi, bye-bye
* - Ownership - me, mine
- Love
- Family members - mom, dad, brother, sister
* - Pets - dog, cat

The 7 starred items are the ones that children normally learn very early, and that you must know in order to communicate with them. They also help the child and you to avoid frustration. For example, a child who can say "help me" will do a lot less fussing or whining to get your attention and help with a problem.

Resource #6B

What Should We Talk About?

Parent Responsibility List

(CMS/Healthdyne Contract)

(Form 8)

1. Attend a 2 to 3 hour training session in monitoring provided by dealer.
2. Tell dealer anything about monitor or monitoring you do not understand.
3. Monitor infant at all times infant is sleeping *or* not being watched by an adult.
4. Respond quickly to an alarm and perform CPR if necessary.
5. Make sure anyone who babysits for infant understands monitor and knows infant CPR.
6. Be available for a home visit by dealer within a week of hospital discharge.
7. Be available each month for a home visit by the dealer (to be made before 25th of each month).
8. Notify dealer of any equipment problems anytime day or night.
9. Fill out the Event Log each time there is an alarm.
10. Provide the completed Event Log to the dealer at the monthly home visit.
11. Provide adequate care for monitor and supplies.
12. Notify dealer if additional supplies are needed.
13. Notify dealer of any change of address or phone number.
14. Notify dealer of any extended visits away from home. (Visits longer than 1 week)
15. Be available for monitor pick-up by dealer upon physician's decision to discontinue monitoring.
16. Return monitor and cases to dealer in good condition when your physician discontinues the monitor.

. . . . . .

Healthdyne Contact:
Dr. B.L. McEntire
Healthdyne, Inc.
2253 Northwest Parkway
Marietta, Ga. 30067
(404) 955-9555

Dealer Contact:

_____

_____

_____

Resource #7A, Responsibility List for Apnea Monitor Users.
From Healthdyne, Inc.

CONSISTENCY:

A Child Management Technique

Consistency is saying something or handling a situation in the same manner EACH TIME IT OCCURS!!

Consistency is needed whenever behavior is to be shaped or modified. When an adult is inconsistent, the child does not know what to expect and therefore will continue to test limits (try something) do things in order to determine what is expected and what it is. If an adult was arrested for speeding in a city where no speed limit signs were posted, he would feel angry and cheated.

To be consistent you must:

* Decide what you want and how you will get results.
* Set clear and reasonable expectations.
* Follow through on what you say.
* Wait for the child to do what you have stated or demanded before going on to another expectation.
* Then carry out your method of obtaining results the same way each time.

EXAMPLES:

How To: Mother decides that Mary is to hang up her good clothes every day after school. Mother tells Mary that she expects this job done before she goes out to play. Each day Mother checks Mary's room. If the clothes are not picked up, Mary cannot go out to play, talk on the phone, etc. until she has done this job. If Mother lets Mary forget a day or does the job for her, it only makes the learning process more difficult for Mary.

(Specific Rule for above behavior: Mary is to pick up her clothes every day after school before going out to play.)

How NOT To: One day John went out and played in a mud puddle. When he came home his mother laughed and gave him a warm bath. The next time John did this he had his best clothes on and the family was ready to go to church. When he came home this time, his mother was very upset and spanked him. Most young children are UNABLE TO DISTINGUISH ONE SITUATION FROM ANOTHER AND THEREFORE WILL BE VERY CONFUSED IF THE ADULTS ARE NOT CONSISTENT IN HANDLING A BEHAVIOR IN THE SAME MANNER EACH TIME IT OCCURS NO MATTER WHAT THE SITUATION.

Resource #8A

Consistency. From the Mendota Mental Health Institute Home and Community Treatment Program, Madison, Wisconsin.

IGNORING

A Child Management Technique

WHAT: Ignoring is a technique to reduce or get rid of behavior you don't want. When you ignore a child's behavior, you purposely pay no attention (in words or actions) to what he/she is doing. **NOTE:** You do **NOT** ignore the child, only the irritating behavior. He soon gets the message that even though you love him, you do **NOT** like and will **NOT** give him satisfaction for the unwanted behavior.

WHEN OR WHY: Use "ignoring" for many MINOR negative behaviors, such as interrupting, quarreling, nagging, whining, commanding adults.

HOW:

1. Decide what minor behaviors you want decreased.
2. Decide whether you can tolerte this behavior without having to remove the child from the area: If you can, use "ignoring" as in 3, 4, 5, and 6 below.
3. Decide what behavior you DO want to see. Be sure both parents know what the child SHOULD do. For example, if Johnny has been noisy at the dinner table, you might decide that after Johnny sits quietly at the table, he will be able to out and play.
4. Either tell the child what behavior you expect or let him/her know what you expect by telling someone else as he/she listens.
5. Continue what you are doing: do not look at or talk to the child.
6. When the child finally does what you told him/her, praise him/her for doing what you directed and let him/her continue as a part of the family.

EXAMPLES:

Mother is talking with a neighbor. Five-year-old Cindy repeatedly interrupts the conversation by calling "Mom" again and again and pulling at her arm.

Resource #8B

Ignoring. From Mendota Mental Health Institute Home and Community Treatment Program, Madison, Wisconsin

IGNORING (Continued)

A Child Management Technique

How NOT To:

Mom: "I'm talking, Cindy."
Cindy: "Mom, Mom." and pulls on Mom's arm.
Mom: "Be quiet!"
Cindy: Repeats, "Mom" in a louder voice.
Mom: "Stop pulling my arm" and pushes Cindy's arm away.
Cindy: Starts yelling at Mom in a loud voice, stamping her feet, pushing Mom away from neighbor, etc.
Mom: "What's the matter, Cindy?"

How To:

Mom decides to ignore Cindy's interrupting behavior. She tells the neighbor that she wants Cindy to learn to wait and asks her not to look at or pay any attention to Cindy's interruptions. Conversation continues between Mom and neighbor. Cindy stops pulling at Mom's arm and stands quietly, looking confused. When there is a break in the conversation, Mom says, "Good waiting, Cindy!" and attends to Cindy's problem.

FOLLOW-UP:

1. Ignoring may be very difficult and at times it is necessary to physically remove yourself from your child's sight.

2. Remember--any attention to the child's minor negative behaviors will only strengthen and probably increase this unwanted behavior.

STOP THE WORLD

A Child Management Technique

WHAT: "Stop the World" brings the child's world to a complete halt until a task that needs to be done is accomplished. He is not allowed to do anything he wants to do until he has done what you want him to do.

WHEN OR WHY: Use "Stop the World" when a child does not do a specific task he has been told to do. When he fails to follow-through (preferring to dawdle, stall, complain, or argue), talking with him or trying to pursuade him will do little good. It only helps to keep him away from doing the task and may give him attention he likes, thereby teaching him to **not** do the task in the future.

How To:

1. State clearly the job to be done.
2. Ask the child what is the next thing he must do.
3. Go about your own business, giving no further attention to the child.
4. Check back on the child periodically to see if he is doing what he should. Do **not** allow the child to participate in any other activity until your initial command has been complied with. If he insists on disobeying you, use "Time-Out" technique, and then return to "Stop the World" technique.
5. Divert or instruct other children not to interrupt the child until he has finished his task.
6. Praise the child as soon as he begins the task, again as he does it, and when he completes it.
7. Whenever possible, "reflect" his feelings about doing the job after he has started doing it.

EXAMPLES:

How NOT To: Jimmy decides he wants to go outside. He leaves his toys on the floor and goes to get his coat. Mom calls after him. "Pick up your toys!" Jimmy mutters, "O.K." and continues to put on his coat. Mom calls out, "What are you doing, Jimmy?" Jimmy answers, "Going outside." Mom yells, "I

Resource #8C

Stop the World. Mendota Mental Health Institute Home and Community Treatment Program, Madison, Wisconsin.

EXAMPLES: How Not To: (Continued)

told you to pick up your toys!" Jimmy approaches Mom saying pleadingly, "Can't I do it later? I promise I'll pick them up after I come inside." Mother waivers--"Well, O.K., if you promise. You know you forgot yesterday and I'll spank you if you forget again." Jimmy's already halfway out the door.

How To: Seven-year-old Jimmy has been playing with his toys. He now wants to go outside. He gets up to get his coat, leaving a mess on the floor. Mom, "Jimmy, you have to put your toys away before you can go outside." Jimmy keeps walking away. Mom says, "Jimmy, what do you have to do before you can go outside?" Jimmy stalls, Mom waits for an answer, Jimmy finally says, "Pick up my dumb old toys." Mom says, "Good, I'm glad you know what you have to do," and moves away. Little brother Bobby goes over to Jimmy and says, "Let's go outside." Mom moves in and tells Bobby that Jimmy has to pick up his toys first. She then ignores Jimmy's stalling and helps Bobby get ready to go outside.

After a while, Jimmy picks up one truck and starts to put it away. Mom immediately praises Jimmy: "That's good Jimmy. I know you want to play outside" (reflection of feeling). Jimmy begins to work a little faster as he sees Bobby playing outside. Mom praises each small step and then heaps on more praise when Jimmy finishes picking up: "You did a good job--I know it's hard to wait to go outside" (reflection of feelings). Jimmy says, "Yeah, I hate cleaning up messes!"

FOLLOW-UP: Be sure to praise the child for all movements toward getting the job done. Tell him clearly when he's completed the task and what it is he can do from then on--for example, that he may continue other activities.

GRANNY'S LAW

Granny's Law involves the combining of two activities - one pleasurable to the child, and one not so pleasurable. The pleasurable activity reinforces doing the less pleasurable activity. Or, work before play; or, first you do what I want, then you may do what you want. Example: When you have picked up your toys you may go out to play.

WHAT TO DO WHEN MAKING YOUR GRANNY'S LAW.

a. <u>You make up the rule</u>.

First_____(what is your child's job?)
Then_____(what can your child do for fun?)

b. <u>Tell your child the rule</u>.

That's it. No arguing, coaxing, nagging.

c. <u>Be a Broken Record</u>.

If your child starts to fuss, stall, or ask "Why?" Say, the rule again. "When your toys are put away, you may go out and play."

d. <u>When your child gets the job done, say something nice</u>.

You don't need to over-do the praise. He's not doing the job just to make you happy! Be sure that your child knows that he earned his fun! You could say something very simple:

"Nice job. Now you can play." or "That's fine. Now you can watch T.V."

e. <u>Your child regulates himself</u>.

You don't have to punish by nagging, scolding, screaming, or hitting. Your child has a choice. If he wants his fun, all he has to do is get his job done!

Resource #8D

Granny's Law: Lee Mental Health Center Parent Education Programs

WHAT TO DO WHEN MAKING YOUR GRANNY'S LAW.

f. Stick with it!

Your child might get very upset because he missed out on some or all of the fun. But, if you want your child to follow your rule, YOU WILL HAVE TO FOLLOW THE RULE, TOO!

A REWARD IS NOT A BRIBE!

What is the difference between a reward and a bribe?

1. A reward is like getting paid for a good job.
2. A bribe is always used with illegal or immoral acts.
3. A reward is for doing what is good or moral.
4. A bribe comes before the desired behavior - a reward comes after the behavior occurs.

PROBLEM SOLVING EXERCISES: Behavior Management

Read the following scenarios and design a behavior management program for the classroom. Try to employ the four techniques listed, but feel free to suggest other methods. Remember to consider the age of the children and the severity and duration of the problem in your suggestions.

CONSISTENCY

IGNORING

STOP THE WORLD

GRANNY's LAW

1. Carlos is a 4-year old boy who has been in your pre-K class a few weeks. Carlos has Down Syndrome. Ever since the end of the first week, after Carlos got oriented to his new room, you have had a problem with him. Carlos wanders! He has trouble staying in his seat for more than 3 minutes at a time. At first he just stood by his desk or walked aimlessly around the room. However, lately he's been taking papers from desks, moving chairs, and distracting others. Today he also wandered out an open door and down the hallway before he was discovered. You were able to ignore his wandering, but leaving the classroom is potentially dangerous for Carlos.

   What would you do?

2. Julie is a 2-year old girl with mild CP and developmental delays. She had a fall several weeks ago, and was in pain from bruises for a week or so. During that time, she whined when carried. The bruises are long gone, but the whining has remained as an off-and-on day-long habit that's driving her caregivers to distraction! You've tried to ignore the whining, but every 10 minutes or so you find yourself touching Julie and saying, "Honey, what's wrong?"

   What would you do to help stop the whining?

3. Frank is a 6-year old child who is hearing impaired. He is in your after school program? Frank signs and speaks, and interacts well with others of his age. The problem is that if Frank doesn't get your attention the first time he tries, he will hit you - hard - on the arm. Frank hits peers, younger children, adults - even the bus driver.

   Why is Frank hitting? What would you do about it?

PROBLEM SOLVING EXERCISES: Behavior Management

(Continued)

4. Melissa is a 3-year old child who is visually impaired. She is accustomed to one-on-one attention at mealtimes, which is impossible in the day care setting. Melissa refuses to eat when the others are eating. However, about an hour later, she cries and complains of hunger. You've been sending her to the kitchen to eat again with the cook, but don't feel this is fair to Melissa, the cook, or the other children.

   What would you do about it?

5. Jason is a 3-1/2-year old with Spina Bifida. He can crawl while dragging his legs, and uses a scooter board to get around. Jason can also climb in and out of a small chair independently and quickly. Jason has begun to "slow down" to get attention. You end up having to wait for him at transition times, and find yourself saying, "hurry up, we're waiting" about 20 times a day. The problem is interfering with everyone's schedule. It also results in a lot of negative attention for Jason, and you sometimes end up picking him up to put him in a chair, just so the group doesn't have to wait.

   What would you do to speed up Jason?